Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Lee Parr Jeffrey **Physician** 2011 /Medical 4a. Facility Name (If not institution, give street and number 4b. City. or Location of Death 4c. County of Death Examiner LOCH RAVEN limo If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday Funeral 226-90-3459 Months Days Hours Min 54 1 M 2 □ F Director 09/09/1956 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at ☐Yes 2☐No Director N/A N/A N/A N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? N/A N/A USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 XYes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ģ Specify: White 3 Novidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Mental Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 12 Transportation Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucindy Craig Rudolph Parr ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lucindy C. Parr/Mother 215 Thorofare Rd, Crimora, VA 24431 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/28/2011 Final Journey crem Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall 21203 Mai Shall Approximate Interval Between Onset and Death 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of) physician the burial Box 68760, Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. i signed by the a d be detached for ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe this certificate 1 ☐Yes 2 ☐ No 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death,
To the Funeral Director; After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier, 02, 2011 m.0

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Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOCH

Year)

900

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jugu. Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner THWEST 9. Birthplace (State or Foreign f Under If Unde 8. Date of Birth Sex 6 1 X M 2 □ F **Funeral** Months Davs Hours Country 082-18-3928 NY Director 87 Usual Residence of Decedent show 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State Director Examiner must be notified 28a-f 1 🗆 Yes 2 😾 No BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 5 10e. Street and Number 23a Funeral 21207 USA 3665 FOREST HILL ROAD items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 0 1 Never Married 2 Married þ Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: id Mental Hygiene. marked other than "natural", 3 ☐ Widowed 4 ☐ Divorced Completed WHITE Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) RETAIL 12 MANAGER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ be f **PUTTERMAN** DORA BAYMAN BENJAMIN and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 1 and 2 s of Health item 27 FRANCES PUTTERMAN/WIFE 3665 FOREST HILL ROAD, BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite any injury or ot 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HILLTOP SERVICE CORP 08/03/2011 TOWSON, MD Signature of Fuperal Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD, 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final NEUMONIA Ph. sician/ disease or condition resulting in death) Medical Due to (of as a consequence of Examiner Sequentially list conditions if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of) Examir and -transit that initiated events resulting in death) Last Due to (or as a consequence of) physician at the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be.
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONBESC VE1 - Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy perform 5/4/48 2 1 NO 1 Tes 1 Yes 2 Division of Vital 25. Was case referred to m 26. Place of Death (Check only one) Be examiner? Hospital: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27, Mann Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 Tes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed To the lewithin 2 To the lewithin 2 only one e of ce 29b. Signature and completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who DRIKNAC

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 25003 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ J. Robinson Bernice 2011 5:30 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Lutherville 17 Old Boxwood Lane 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year] 192<u>8</u> July 01 Days Hours Min 1 M 2X F Delaware 83 222-16-6657 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b County 10a. State within 72 hours after death with the Maryland Director 1 ☐ Yes 2 No Lutherville Baltimore MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21093 17 Old Boxwood Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify 3 Widowed 4 Divorced White Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Jeffery unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17 Old Boxwood Ln. Lutherville, MD. 21093 Harry Robinson/ Husband injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Timonium, MD. Dulanev Valley Mem. 8-8-11 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 21. Signature of Huneral Service L any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying or as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months? Month Other (specify) Pregnant at time of death a 🗌 Hnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy death? 1 ☐ Yes 2 🔀 N 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No М Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 20d Date signed (Month, Day, Year) 29b. Signature 29c. License number 20649 20 10 m address of person who completed cause of death (Item 23a) (Type, Print) 30. Name

Registrar

State

10

31. Date filed (Month, Day, Year)

32. Registrar's Signature

utherville.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Joan Rolfes Frances Physician/ 20<sup>rear</sup>1 11:42PM August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester 8701 Mediterranean Drive 0cean City 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F 217-38-8067 69 Yrs 09/30/1941 MD Director Usual Residence of Decedent 10b. County 28a-f shor 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director notified Ocean City MD Worcester 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ıral", or items 23a o Examiner must be 8701 Mediterranean Drive 21842 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 1 Black, White, etc. by 1 Never Married 2 Married filed within 72 hours after al Hygiene. d other than "natural", or Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: <sup>Specify:</sup> White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1.2 <u> Heathcare</u> <u>Registered Nurse</u> Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Helen Stafford John L. Herman Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 Oakdene Rd., Baltimore, MD 21220 19a. Informant's Name/Relationship (Type, Print) Daughter Karen Goodspeed timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Final Journey crem. 1 Burial 2 X Cremation 3 Removal from State 8/6/2011 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Bal Maryland PO Box 14 Cremation Services iaisuall Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to for as a consequence of if any leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Date filed (Month, Day, Year)

AUG 0 5 2011

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Aug Day 0 1 1 Year Ann C. Shindledecker 3 Physician/ a M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Essex 715 N. Woodward Drive 8. Date of Birth (Month, Day, Ye Jan. 25, Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number | 212–32–9955 **Funeral** 1 🗆 M 2 🔀 77 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State Director Essex Baltimore MD 1 Yes 2 XNo 10f. Zip Code 21221 10g. Citizen of What Country? 10e. Street and Number Woodward Drive Funeral 715 N. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Specify: White If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) ife. DO NOT use retired) Martin Co. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Augasta ဂ္ Lou Lackl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 N. Woodward Drive Balto. MD 21221 Marvin Shindledecker /husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Denial 2 Cremation 3 Removal from State Holly Hill Cemetery 8/6/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Sign wire of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to ( as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Dergen or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Other (specify) Pregnant at time of death signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen: 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No iniury Natural 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and th 29d. Date signed (Month, Day, Year) 100 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

Registrar's Signature

AUG 0 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25006 8/6/httifigate of Death Registraramend 20a-22 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year can Smith 1312 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Kegional pital 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Days Hours 1 M 2 XF Year) Months Director Mari Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No PG 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20707 USA 8212 Avenue within 72 hours after death . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1'X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Divorced 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) of Health and Mental Hygiene of Health and Mental Hygiene of Health 27 is marked other the rother traumatic event, the None None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ orenzo 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Roral Route Number, City or Town, State, Zip Code) Riles 8212 MD lother aurel Gorman 20707 ranel 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 😾 Other (Specify) 21. Signature of Funeral Service Licensee

Ronald S. Wade (per DVR) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St. 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Extreme Medical resulting in death) Due to (or as a consequence of) Examiner remosoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner ue to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Dloid 100 and Due to (or as a consequence of) attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as the ! IF FEMALE: yes, outcome of pregnancy nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months? Month Day Year Pregnant at time of death the detached a Unknows sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No Yes 2 ☐ No Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 XInpatient 2 🗆 ER/Outpatient 3 DOA Hospital or Attending Phys 24 hours after death. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 201 Termela 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aurel, MB 2070 Uchella

State Registrar

AUG

Year)

2011

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25007 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 2011 Susan Sunstone 2:14 A M 31 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 5478 Cedar Lane #A2 Columbia Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Virginia 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 - M 2 X F Days Hours 11771071951 225-66-2131 Director 59 Yrs. show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 28a-f Howard Columbia MD 1 X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21044 USA Funeral 5478 Cedar Lane #A2 death v r than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Ş ☐ Yes 2**X** No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Private Sales Representative event, t Be 17. Father's Name (First, Middle, Last) LINK 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic ever မ Ann Morrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5478 Cedar Lane #A2, Columbia MD 21044 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Heatth an Important: If item 27 is any injury or other trau Priscilla Sunstone (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Quantico National 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 8/9/2011 Triangle, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latimore Funeral Services, PA 2818 E. Baltimore Street, Baltimore MD 21224 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complisations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Tooth infection Medical Due to (or as a consequence of) **Examiner** Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami <u>Hypertension</u> and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Box 68760 as the b IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Dav Pregnant at time of death Other (specify) 1 Yes 2 2 the a detached 9 Unknown Division of Vital Records, P.O. þ ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 X No 2 No 1 Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \sum \) No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred ✓ Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of

31. Date filed (Month, Day, Year) AUG 0 5 2011

Kisha Davis, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 [

5500 Knoll North Drive, Ste 370, Columbia MD 21045

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0065224

29d. Date signed (Month, Day, Year)

2011

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25008 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 20 TT SAPPINGTON 8:05 A M MARTE BABBETTE Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 □ M 2**X** F 08/24/1914 Maryland Director 96 215-10**-**2034 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 X No Kingsville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral U.S.A. 21087 7011 Mt. Vista Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Force 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes. Give Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education 12 <u>Secretary</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Winifred Christopher <u>Charles Uhing</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2900 Houcks Mill Road - Monkton, Maryland Barbara Lynn Klein (daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Cemetery 08/06/2011 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fhysician, disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or se a consequence of) if any, reading to infinediate cause. Enter Underlying Cause (Disease or iinjury cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 No Month Day 9 Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 ☐ Yes 2 ☒ No certificate h within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 🔲 Yes 2 🗌 No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1 032279

3 5 m

Registrar
DHMH 17 Rev 7/2009

State

MACPHAIL ROAD

32. Registrar's Signature

21014

BEL AIR MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W

DAVID DUNN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year AMBROSE PAUL SHINSKY 5:15 PM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Rosedale Hospital ('enter nitimore If Under 1 Year | If Under 24 Hrs. Social Security Number Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days 1X□ M 2 □ F Months Hours JUNE 15. PENNSYLVANIA **Director** 216-20-4342 84 1927 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Medical Examiner must be notified at Director MD BALTIMORE OVERLEA 1 Yes 2 No ь 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 23a Funeral 5713 EAST AVENUE 21206 USA items 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after d Health and Mental Hygiene. tem 27 is marked other than "natural", or i 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify: 3 ₩ Widowed 4 Divorced Completed Year or Dates.45-46 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the TELEPHONE COMPANY 12 REPAIR FOREMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CASIMIR SHINSKY VICTORIA CHECONSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau SHARON KOZLOWSKI-DAUGHTER 806 DELRAY DRIVE FOREST HILL, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 8/4/2011 BALTIMORE, MARYLAND GARDENS OF FAITH 21. Signature of Fineral Service Ucensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME 6415 BELAIR ROAD BALTIMORE, MD 21206 11 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ ardingenic Medical resulting in death) Due to (or as a consequence of) Examiner Julti-organ Failur Sequentially list conditions, if any leading to in modern cause. Enter Underlying Examine Due to (or as a consequency of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury actic Acidosis that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Renal Sepsis Disease 2 No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practigner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 8 MD D0053694 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shinners Franklin Square Drive Baltimore,

Registrar

State

31. Date filed (Month, Day, Year) AUG 05 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	State of Maryland / Department	artment of Health and N rtificate of Death	lental Hygiene Reg. No	2011 25010						
Physicia	ın	1. Decedent's Name (First, Middle, Last)  David  Scott		2. Date of Death Month Day	Year 3. Time of Death						
/Medica Examine Funeral	er	4a. Facility Name (If not institution, give street and number)  Johns Hopkins Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death  Baltimore City  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)						
Director		577-78-5841		07/07/1959	9 Egypt  10d. Inside City Limits						
Marylar a-f show	ctor	10a. State 10b. County 10c. City, Town or Lo			1⊠Yes 2□No						
with the	Director	10e. Street and Number 3532 Roland Avenue	10f. Zip Code 21211		.S.A.						
be filed within 72 hours after death with the Maryland the Hydjene.  do other than "natural", or items 23a or 28a-f show event, the Madical Evenien chart to notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 🕅 Married 1 □ □ Ves 2 □ ▼ 1 □ □ Ves 2 □ ∇ 1 □	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.  Specify: White						
in 72 hours in "natural"	Completed b	15 Daniel Advention 16a Dane	edent's Usual Occupation be kind of work done during most of work DO NOT use retired)	ing	(ind of Business/Industry						
e filed within al Hygiene.	Com	12 Col	mputer Technician 18. Mother's Nam	Info	ormation Technology						
2 should be f and Mental is marked o	To Be	David Scott	Matilda								
of Health and Ment of Health and Ment item 27 is marked rother traumatic e		1 1 2	ing Address <i>(Street and Number or Ru</i> 2 Roland Avenue, I								
permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiens in Important if item 27 is marked other than "natural", or any injury or other traumatic event, the Madical Eventonce.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  4 ☒ Donation 5 □ Other (Spe#iy)  20b. Place of Disposition ceretery, cre  Anatomy G	osition (Name of matory or other place)	Date 20c. L 1/2011 Han	over, Maryland						
permit. Departn Importa any inju			2. Name and Address of Facility Ar 522 Connelley Dr.								
Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Multingan Failure resulting in death)		or respiratory arrest,	Approximate Interval Between Onset and Death						
Medical be executed Examiner be executed buy sicien and buy sicien and sthe burial-transit	Examiner	Due to (or as a consequence of):									
ne death certi the attending	ysician/Medical	ysician/Medica	ysician/Medica	ysician/Medica	ysician/Medica	ysician/Medica	Physician/Medica		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
w requires that the seen signed by should be detact	ð	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of d							
The law recicate has bee	Completed			24a. Was an autopsy performed? 1 □ Yes 2 □ N	24b. Were autopsy findings available prior to completion of cause of death?  1 □Yes 2 □No						
Physician: The Physician: The rational	o Be	25. Was case referred to medical examiner?  1 ★ Yes 2 No  Hospital: 1 ★ Inpatient 2 □ ER/Outpatie	Other:	th (Check only one)  lome 5 ☐ Residence	6 ☐ Other (Specify)						
ath.	Certification: 1										
To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and plac investigation, in my opinion, death occ	l e, and due to the cause urred at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s)						
To the within: To the comple	Med	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)						
		30. Name and address of person who completed cause of death (Item 23a) (Type Adam Shaner GUU N, Will 31. Data field (Month Den Year) 32. Registrar's Significant S	FE STREET, BAL	TIMORE, M.	gust 3, 2011 ALY/AUD 21287						
Sta Registr		31. Date (fied (Month Den Year) 32. Regisfar's Significant Signifi									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25011 20 I Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20118:10 AM August Samuel Gilbert Steen Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 713 Old St. Mary's Road Harford Pylesville 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F Months Days Hours Min. Maryland Director 213-32-8797 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director 1 Yes 2 X No Collier FL Naples 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral U.S.A. 5880 Three Iron Drive, Unit #803 34110 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) anould be filed wrealth and Mental Hygie. m 27 is marked other the Attorney at Law Legal Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta. Importment of Health and Menta. Importment: If item 27 is marked any injury or other traumastic. မ Samuel Gilbert Steen, Furv Sr. Teresa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5880 Three Iron Dr., #803, Naples, FL 34110 <u> Eileen Steen / Wife</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 08/04/2011 | Hanover, Maryland 21. Signature o Juneral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph\_sician/ STAGE disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events the burial-transit resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 □ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has death? 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 X No 6 Nother Specific ERS HOUSE ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 28b. Time of Manner of Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 📃 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 State Registrar

3

7 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ida Groves Sprinkel August 2011 4:00 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** tc. County of Death Harford County Forest Hill Senator Bob Hooper House i. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days 211-20-0764 1 □ M 2 🗙 F 82 Months Hours Director 1928 Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at **Funeral Director** Clearville Bedford 1 Yes 2 No PA 10e Street and Number 10f. Zip Code 15535 10g. Citizen of What Country? United States 3079 Clear Ridge Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 44645T 4,2011 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Flannigan Edgar Clements 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2441 Rocks Road Forest Hill, MD 21050 Eileen Campbell / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Auq Dat 5 1 Burial 2 X Cremation 3 Removal from State Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 2011 Forest Hill, Maryland Air Evans Funeral Chapel & Cremation Service—BelAir 13 Newport Drive Forest Hill, Maryland 21050 21. Signature of Faneral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRUNIC OBSTRUCTIVE PULMUNARY
DISEASE Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 SPRINKEL IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate has 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death ne Hospital or Attending Pt n 24 hours after death. Ie Funeral Director; After the 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident iniury 5 Pending 2 🗆 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Vithin 2 only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

AUG 05

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
5, 7 per MO/FH 9918 8/5/11 TT
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month MacKenzie Rayne Shiflett 2011 3/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BalTimore FRANKLIN Square Hospital Rosedal If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 - M 2 X F Days (Month, Day, Year Months Hours unk Yrs **Director** July\_ 201 Maryland Usual Residence of Decedent or 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Me A al Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Marvland Baltimore Edgemere 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3208 Lynch Road 21219 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 and 2 should be filed within 72 hours afte. Health and Mental Hygiene. tem 27 is marked other than "natural", 1 ☐ Yes 2 😾 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kelley A. Fisher Dustin M. Shiflett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Edgemere, Maryland 21219 Dawn M. Shiflett (Grandmother) 3208 Lynch Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 8/4/2011 Holly Hill Mem. Gdns. Middle River, Md. 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Dundalk, Avenue art 1. Enter the disease , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between shock, or heart failure Immediate Cause (Final disease or condition Onset and Death Ph sician/ PrematuriT 33 minutes Extreme Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examine Due to (or as a consequence of): attending physician and for use as the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical equires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed phous 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician; The law has le 2 prior to completion of cause of death? autopsy performed page 1 Yes 2 No this certificale 2 🚅 **Division of Vital** 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred After injury (Month, Day, Year) 1 Natural 5 Pending 24 hours after death.

Funeral Director: A 2 Accident 1 ☐ Yes 2 ☐ No М Investigation the To the Hospital or Atter within 24 hours after der To the Funeral Director completed filled in by th 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WD 31 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN Square DR Balt md 21237 DR Sarah L Harper 9000

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Restrar's Signature

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 9:18 William G. Schuler Ju1vMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u>Gilchrist Hospice</u> <u>Baltimore</u> Towson 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month. Dav. Year) Hours 1 X M 2 🗆 F Country) Director 91 29 191 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director or 28a-f sh notified a 1 Yes 2XXNo Marvland Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ь must be r Funeral 21222 United States 7315 Old Battle Grove Road "natural", or items dical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 White 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ealth and Mental Hygiene. n 27 is marked other than er traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Licensed Plumber Maintenance 11 years ed other event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ William R. Schuler Ethel Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) fitem 27 Dundalk, Maryland 21222 7315 Old Battle Grove Road Edna L. Schuler Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem, Park 8/4/2011 Elkridge, Maryland Signatur Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc 7922 Wise Avenue Dundalk, Maryland 21 Wise Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ heart disease or condition resulting in death) Concestive reary Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin ending physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Day Pregnant at time of death ☐ Pregnam ☐ Unknown detached 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Director: After this certificate d in by the funeral director, pag 2 🗌 No Yes 2 IN 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Hospita Other: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Pending 1 Yes 2 No Accident Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Hospital Medical 29a. Certifier 🚅 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MD 00070635 10 . An 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 Pate Somte 4105 Bultimores N Charles MD 31. Date filed (Month, Day, Year) State AUG 05 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25015 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:02P M Physician/ HUGUST 2011 Elinor Willing Scriba Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Towson 4c. County of Death
Baltimore **Examiner** Saint Joseph Medical Center 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Mary land Aug. 20 1 □ M 2 🗓 F Months Days Hours 1929 81 **Director** 217-24-1588 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location Directo 1 Yes 2 No Timonium MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral USA 21093 12300 Rosslare Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Yes Give Completed 3 Widowed 4 Divorced white Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma Messick James McKendry Willing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12300 Rosslare Ridge Road #308; Timonium, MD 21093 Edwin William Scriba / husband 20a. Method of Disposition 1 D Burial 2 Crer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Cremation 3 - Removal from State Druid Ridge Cemetery 8/6/2011 Pikesville, MD 4 Donation Other (Specify) 22. Name and Address of Facility 1050 York Road Signature of Fu Towson, MD 21204 Ruck Towson Funeral Home, Inc. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one c Immediate Cause (Final Ph, i i n/ ARDIOGENIC SHOCK disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: attendin for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 18 months?
1 Yes 2 No Month Day Year Pregnant at time of death the g Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 700 3 Probably 4 Unknown RESPIRATORY FAILURE 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? 1 🔲 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Natural 28d. Describe how injury occurred s after death.

I Director: After the din by the funera injury 5 Pending Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date sig ned (Mont), Day, Year) 29c. License number D24034 Der

Registrar DHMH 17 Rev 7/2009

State

OSLER DRIVE

32. Registrar's Synature

TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601

M.D.,

LOW

YHTOMIT

31, Date filed (Month, Day, Year) AUG 0 5 2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For	State of Mar	yland / D	epartme	ent of He	alth and N	Mental Hy	giene			
			State Registrar	Certificate of Death					Reg. No. 2011 250				NE
	Physici Medi		1. Decedent's Name (First, Middle, Last)	Joyce Ford Starling					2. Date of Dea	Dav	Year	3. Time of	Death P M
	Exami		4a. Facility Name (if not institution, give s	treet and number)		4b. Ci	ty, Town, or Lo	ocation of Death		4c. County	of Death		
		,	Franklin Squar  5. Social Security Number 6. Sex		h yrs. last birtho		Sedal der 1 Year	C f Under 24 Hrs.	8. Date of Birt			rore	_
	Funeral Director			M 2 XF	79 Yr	Month		Hours Min.	(Month, Day		9. Birting Count	lace (State or ry) NC	r Foreign
	Mo d	١.	Usual Residence of Decedent						104702	1752			
	Maryland 28a-f sho otified af	rector	10a. State 10b. County MD	1	0c. City, Town o	r Location		Bal	timore		1	0d. Inside Cit 1 <b>X</b> Yes	-
	with the I	Funeral Director	10e. Street and Number 6802 Averil	l Road, A	Apt. T		Zip Code 212	37		10g. Citizen of V	Vhat Coun	*	
"	er death or items niner m	by Fun	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Eve Armed Forces? 1  Yes 2 X				anic Origin? (Spe Mexican, Puerto			e - America k, White, e		
-0036	ours after attural", cal Exar	eted b	3 ☐ Widowed 4 🔀 Divorced  15. Decedent's Edu	If Yes, Give Year or Dates.			2 XNo S				Whit		
4 cc, 5+arling Maryland 21215-0036	thin 72 h sne. than "n he Medi	Completed	(Specify only highest grad Elementary/Seconday (0-12)	e completed) College (1-4 or 5+)	(6	Give kind of vie. DO NOT u	vork done duri use retired)	ng most of work	ing	16b. Kind of Bu			
7 7	ed wil Hygie other ent, th	Be	12 17. Father's Name (First, Middle, Last)	5+		T	eache:		ne (First Middle		lucat	tion	
1 S 1	uld be fil Mental narked natic ev	P	17. Father's Name (First, Middle, Last)  George Ira Ford  18. Mother's Name (First, Middle, Maiden Su  Vera Belle Bre										
	nd 2 shou ealth and n 27 is n		19a. Informant's Name/Relationship (Typ Michael I. Sta:		19b. N	Mailing Addre	hopata	Number or Rura ank Ave	e., Cai	; City or Town, S nbridge	tate, Zip C MI	216	13
Jo J	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of D cemetery, Final	crematory o	r other place)		Date 2011	20c. Location - Woodbin	•		
Balt	permit. Departi		21. Signature of Funeral Service Licensee	Dorota Ma	rshall	22. Name	and Address of Maryl PO Bo	and Cr x 1413	ematio . Balt	n Serv imore,	ices MD	21203	
			23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only one	cations that caused the cause on each line.	e death. Do not	enter the m			_			Approximate Interval Bety	e ween
- 4	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Pulmo	nacy	En	bole	45				Onset and D	)eath
1	Examiner		Tooding in death,	Due to (or as a co	onsequence 1:								
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury										
	ate be executed physician and the burial-transit	Examiner	that initiated events c		geni	C 5	hock	Υ					
	e execian a	a	resulting in death) Last	Due to (or as a co	opsequence of):								
760	cate b physi	edical	d	·									
Box 687	or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transis.	Physician/M	FEMALE:  3b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1  Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify)							23d. Dai	e of delive	,	⁄ear
P.O.	ad by detach	/ Ph	Part II. Other significant conditions con	tributing to death but r	not resulting in t	he underlyin	g cause given	in Part I.	23e. Did to	bacco use contr	ibute to th	e cause of de	eath?
	requires that the de been signed by the should be detached	Completed by							1 🗆 🕆	res 2□No	es 2 No 3 Probably 4 Vunknown		
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/ita	/sicia s certi	To Be	examiner?	ospital:	2 ER/Outpa	ationt 2 🗆	Other:	of Death (Check		ence 6 🗆 Othe	··· (Oif-i		
of	ig Phy ter thi		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Yo	28b. Tim	e of	28c. Injury at work?			ow injury occurre			
on	tendir eath. or: Af the fu	lica	1 Matural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(World, Bay, 1	our, Inju	M		3 □ No					
Division of Vital Becords.	tal or Attending Physician: The law rs after death. al Director. After this certificate has ed in by the funeral director, page 2 to	l Certificate:	4 Homicide determined	28e. Place of Injury building, etc. (S		street, facto	ory, office		28f. Location (S City or Tow	treet and Numbe n, State)	er or Rural	Route Numb	er,
00	To the Hospital or within 24 hours after To the Funeral Direction completed filled in the filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine 3 Certifying Nurse	r: On the basis of exam	nination and/or in	vestigation, i	n my opinion, o	death occurred at	t the time, date a	nd place, and due	to the cau	ise(s) and mai	nner stated.
-10	To the Com		29b. Signature and title of certifier	patelino	/	2	9c. License nu	mber		29d. Date signed			
	1		, 7	! /			Res	2000		8-3-	20	//	
_	0		30. Name and address of person who cor	npleted cause of deat	h (Item 23a) (Typ	o Print)							
	Sta	10	31. Date filed (Month, Day, Year)	Jel 900	OO T	20K1	n 594	are Dr	ive Ba	1+1mg	000	MD 3	11.337
	Sta Registra		AUG 0 5 2011 /2	ever S.	Marke								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2501 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary Patricia Sands 5:08 August 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 701 Raynor Avenue Catonsville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign
Country) **Funeral** (Month, Day, Year) Apr 28 1950 1 □ M 2**X** F Months Min. Director 219-52-5586 61 Maryland Usual Residence of Decedent r 28a-f show notified at 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Catonsville oe filed within reme. ental Hygiene. "reted other than "natural", or items 23a or 28 rite event, the Medical Examiner must be no 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 Raynor Avenue 21228 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ρ 3altimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Manager 11th Grade Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of Glenn Crumling Mary Volkman permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Justin Sands - SON 701 Raynor Avenue, Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory INC 08-03-2011 Baltimore Maryland signature | f Funeral Service Licensee 22. Name and Address of Facility Cremation Society Of Maryland INC 299 Frederick Road, Baltimore MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death CANCER Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) 2 MONTHS Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-t Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, | 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No 1 Tes ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Directory Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Decition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Number Practioner. To the control my knowledge death occurred at the time, date and place, and the consequence of the control my knowledge death occurred at the time, date and place, and the consequence of the control my knowledge death occurred at the time, date and place, and the consequence of the control my knowledge death occurred at the time, date and place, and the consequence of the control my knowledge death occurred at the time, date and place, and the consequence of the control my knowledge death occurred at the time, date and place, and the control my knowledge death occurred at the time, date and place, and the control my knowledge death occurred at the time, date and place and the control my knowledge death occurred at the time, date and place are the control my knowledge death occurred at the time, date and place are the control my knowledge death occurred at the time, date and place and the control my knowledge death occurred at the time, date and place are the control my knowledge death occurred at the time, date and place are the control my knowledge death occurred at the time, date and the control my knowledge death occurred at the time, and the control my knowledge death occurred at the co 29c. License number DOO 69300 Payer, 3, 2011 29b. Signature and title of certifier M·D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7141 SEC URITY BLVD, BATTIMORE, MD 21244 31. Date filed (Month, Day, Year) AUG 0 5 2011 32. Regigrar's Signature State

DHMH 17 Rev 7/2009

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month OS Year Day O3 Physician/ (0020M ELAINE SHORTER 2011 Medical 4c. County of Death N/A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMO HOSPITAL AGNES 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 😾 F 217-20-8395 94 Director MARÝLAND 14 - 1917Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Event...... 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 XYes 2 No N/A BALTIMORE MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21228 6309 CRAIGMONT RD. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ò If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: BLACK 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12)
-12-STATE OF MARYLAND CLERICAL Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RACHAEL THOMPSON ဨ ERNEST COOPER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6309 CRAIGMONT RD. BALTIMORE, MARYLAND 21228 DORNE LYLES (DAUGHTER) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 ☐ Burial 2 X gremation 3 ☐ Removal from State METRO CREMATORY 8-5-2011 BALTIMORE, MARYLAND 4 ☐ Donation S ☐ Other (Specify) HIBNER2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signatur LicepeeLONATHAN D. BALTIMORE, MARYLAND 21217 1721-27 N. MONROE ST. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between On at and Death Immediate Cause (Final disease or condition Pneumonia Pnysician/ Medical resulting in death) Due to (or as a consequence of) Examiner exacerbation ROUNS if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated event) leads Due to (or as a consequence of): Examir CHF the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran: Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Shortest, Claim B. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Year Month Day 5 Other (specify) Pregnant at time of death Unknown the been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☑ No After this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) | <u>@</u> examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Tyes 2 No Certificate: To 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 1 Natural 5 Pending within 24 hours af er death. To the Funeral Director A ☐ Accident Investigation 6 Could not be 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) filled ir by 4 Homicide determined Medical 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 081 03 D 2406 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2a 2a Pe 1 960 Ceton MD-21229 Cation 900 31. Date filed (Month, Day, Year) egistrar's Signature 32 State AUG 0 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Year Indmas 2322 ⋈ August Physician 201 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOPKINS Baltimore The Johns HOSPITA 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 ☐ M 2 🕶 1-3-1936 Usual Residence of Decedent (Irainia Director 0d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland 10b. County 10a. State 1 ⊈es 2 ☐ No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examines must be notified. Director timore 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Specify Blac 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 **□**√o Specify. þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 18. Mother's Name (First, Middle, Maden Surname) er's Name (First, Middle, Last) 17. Fath Be lilliams ဂ Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 21. Signature of Funeral Service Licenses M01636 23a. Part1. Enter the sease, complications that caused the death. Do not enter the mode of long, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiovascular Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be executed for use as the burial-transi Exami and Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical this certificate has been signed by the attending I al director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 □ Yes 2 🗆 No 9 Unknown 9 Minknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 □Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident I or Attend after death Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide determined 4 🗌 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier Completed cause of death (Item 23a) (Type, Print) 30. Name and addless of derson 600 North Wolfe St Baltimore MD, 21267 KODNE

DHMH 17 Rev 1/2001

State Registrar Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar 25020 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ +1-BERT JULY 20<sup>Year</sup>1 Medical 28 8:25 PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 **▼** M 2 □ F Director 219-56-6274 08-14-1953 Yrs. Mary Land Usual Residence of Decedent show within 72 hours after death with the Maryland 10a State 10b. County notified at Director 10c. City, Town or Location 10d. Inside City Limits 28a-f Maryland Baltimore Towson 1 Tes 2 X No 10e. Street and Number must be 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1013 Timber Trail Road 21286 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 14. Race - American Indian, ģ 1 Never Married 2 XMarried Black, White, etc. Baltimore, Maryland 21215-0036 Completed 3 Widowed 4 Divorced 1 Yes 2X No Specify: Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Salesman 1 and 2 should be filed wi f Health and Mental Hygie item 27 is marked other Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Henry Taylor, Jr. Anna M. Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau <u>Frances Y. Taylor (wife)</u> 013 Timber Trail Road Towson Md.20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20c. Location - City or Town, State 0ak Lawn Cemetery 08-02-2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funer
7922 Wise Avenu Funeral Home of Dundalk, Inc. Avenue Dundalk, Md. 21222 23 Fart 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart finite. List only one cause on each line.

Immediate Cause (Final SMAT.T. CET.T. CARCTNOMA OF THE TJING Approximate Interval Between Physician/ Onset and Death 27 DAYS disease or condition resulting in death) SMALL CELL CARCINOMA OF THE LUNG Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated see or lingury Examine Dina to (or as a consequence of, that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ctopic pregnancy
5 Other (specify) Pregnant at time of death the Month Day Year 9 Unknown q Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? CONGESTIVE HEART FAILURE Completed 1 X Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY DISEASE page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N Hospital or Attending Physician; The certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes မှ 1 Inpatient 2 K ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending s after death. Accident Suicide Investigation 1 ☐ Yes 2 ☐ No completed filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The second of the least of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License numbe D0050736 1080

Registrar

State

68760

Box (

P.O.

Records,

of Vital

Division

7801 YORK RD SUITE 102 TOWSON, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAREN KONKEL M.D.

31. Date filed (Month, Day)

Ξ'			For State	State of M	1aryland	I / Depa	rtment of l	Health Death	and M			• •	2502
			1. Decedent's Name (First, Middle, Last)  2. Date of Death									3. Time of Death	
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and the	Examin	er	4a. Facility Name (if not institution, giv Saint Joseph			^	4b. City, Town, o	Tov	of Death		4c.	County of Deat Haltim	iore
	Funeral		5. Social Security Number 6. 9	Gex 7. A	ge (In yrs. las		If Under 1 Year Months Days	If Under Hours		8. Date of Birt		9. Bird	thplace (State or Foreigi
	Director		218-72-2467 Usual Residence of Decedent		5	5 Yrs.		1		June 20	), 1	956 Mar	yland
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	s 23a o	Funeral	10400 J. Barrett	s Delight	Drive			21030	C			US	-
	r death or item iiner m		11. Marital Status  1XXNever Married 2  Married	12. Was Decedent Armed Forces 1 \(\sum \) Yes 2	7	13. W	as Decedent of H Yes, specify Cub	lispanic Ori an, Mexicar	igin? (Spec n, Puerto R	ify Yes or No- lican, etc.)		14. Race - Ame Black, White	
900	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	J NO	1	☐ Yes 2 🏿 No	Specify.	*			Specify:	White
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and	be filed wit ental Hygie ked other ic event, th	To Be	17. Father's Name (First, Middle, Last)	Фандон	Tee			18. Moth		(First, Middle,		,	
aryl	nould be file and Mental s marked o umatic eve	ľ	Clarence 19a. Informant's Name/Relationship (		Jr.	19b. Mailin	g Address (Street	and Numb	-		_	nson Town, State, Zij	o Code)
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nore	ige 1 a nt of H t: If ite / or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [		_ cer	metery, crem	sition (Name of atory or other pla 111ey Mer			ate /11		ocation - City or	Town, State Maryland
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of F Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Spec 21. Signatur C F next Service Lice	1 1	pura								Home, Inc.
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	Physician/		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on each III	ne.	Do not ente	r the mode of dylr	ng, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
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	Examiner	er	Sequentially list conditions,	b	ATION		JMONIA						5 DAYS
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	. ILEUS		100-01,							11 DAYS
	ite be executed hysician and he burial-transit	al Ex	resulting in death) Last	Due to (or as	s a conseque	nce of):							
1200	icate b g physi is the b	fedical		d							_		
Box 687	death certificate be executed he attending physician and ed for use as the burial-transi	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal	death 3	Ectopic pregnan	су			1	23d. Date of de	,
. Bo	ne deat / the at ched fo	Physician/Me	1 Yes 2 No 9 Unknown	4 ☐ Pregnant 9 ☐ Unknown		ath 5	Other (specify) _					Month	Day Year
P.O.	law requires that the de has been signed by the i p 2 should be detached		Part II. Other significant conditions	contributing to death	but not resul	ting in the ur	nderlying cause gi	iven in Part	I.				the cause of death?
rds,	equire	eted	ASTHMA MORBID OBES	TMV									robably 4 Unknow
Division of Vital Records,	The law cate has be page 2 s	Completed by	MORBID OBES	T T T						24a. Was a autop perfor	SV	prior to death?	topsy findings available completion of cause of
talF	sician: The certificate irector, pag	BeC	25. Was case referred to medical examiner?					lace of Dea	ath (Check		2 IA NO	ol 1 res	s 2 No
ję Vi	Physion this contained and the	은	1 Yes 2 No  27. Manner of Death	Hospital:  1 🗶 Inpa  28a. Date of in	iury 2	R/Outpatient	28c. Injur	4 L N		ne 5 🗆 Resid		Other (Spec	cify)
on c	ending sath. or: Afte he fune	ficate	1 Natural 5 Pending 2 Accident Investigation		ay, Year)	injury	wor	k? Yes 2		od. Describe ii	Ove injur	y cocamoa	
ivisi	or Atter after de Directo in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of Ir	njury - At hometc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		2	8f. Location (S City or Tow			ral Route Number,
۵	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical		ysician: To the best of									
	the Hothin 24 the Formplete	Me		rse Practioner: To th				ne time, date		, and due to the	e cause(s		
			▶ Pale	me -	M.U	1.		5045			290. Da	12/11	i, Day, Tear)
	Ogn		30. Name and address of person who	completed cause of							-;/-		
	Sta		FREETAM JOLES 31. Date filed (Month, Day, Year)	ALEM, M.J			SLER DR	IVE	TOWS	SON, MI	ARYI	LAND	21204
	Registr		AUG 0 5 201		, A.	have	2						

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			State of Maryland / Department	artment of Health and Natificate of Death	Mental Hygiene Reg. No.	71111 /511/7
			Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia Medic		Margaret J. Tighe		August 2,	y 2011 8:23 A M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
and!			Dacota-Broadcreek  5. Social Security Number   6. Sex   7. Age (in yrs. last birthday)	Whiteford If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	larford  9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number $ \begin{array}{ccccccccccccccccccccccccccccccccccc$	Months Days Hours Min.	oct. 2, 192	22   Country   Ireland
			Usual Residence of Decedent			
	yland •f sho ed at	ctor	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	e Mar r 28a notifi	Dire	MD Harford Whiteford  10e. Street and Number	10f. Zip Code	10g Cit	izen of What Country?
	vith th	Funeral Director	4403 Flintville Road	21160	USA	2011 OF WHAT OSCILLY
	eath v	Fune	11 Marital Status 12, Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
36	ifter d ", or i amin	by	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2X No Specify:		Black, White, etc. Specify: white
Ö	ours a aturali sal Ex	Completed	3 X Widowed 4 Divorced Year or Dates.	ind of Business Industry		
15	n 72 ha	mple	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worl 10 NOT use retired)	king	TIO OF Business industry
212	within giene er tha		Elementary/Seconday (0-12) College (1-4 or 5+) Homema	aker	Owr	n Home
nd	e filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maiden S	Surname)
7	uld bu d Mer mark natic	T <sub>3</sub>	John Kerrigan  19a. Informant's Name/Relationship (Type, Print)  19b. Maili	ng Address (Street and Number or Rui		Town State 7in Code)
Ma	2 sho Ith an 27 is			Gunhill Circle; I		
re,	1 and of Hea item other	3	20a. Method of Disposition 20b. Place of Dispo			ocation - City or Town, State
<u>E</u>	Page nent c ant: If ury or			s Long Green 8/6,	/2011 Hyd	ies, MD
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fund Struce Livens	2. Name and Address of Facility		1050 York Road
_	<u> </u>		23a. Part 1. Enter the disease, or complications the caused the death. Do not ent	uck Towson Funera		. Towson, MD 21204
			shock, or heart failure. List only one cause of ach line.		or roopiratory arrost,	Interval Between Onset and Death
	Medical		Immediate Gause (Final disease or condition resulting in death)  a. Due to (or as a cons. quence of):	<u>,er</u>		5 Months
	Examiner					
	_ +	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying			
	scuted and transi	xam	Cause (Disease or injury that initiated events C.			
	te be executed nysician and ne burial-transi	dical Examiner	resulting in death) Last Due to (or as a consequence ot):			
190	icate l g phys is the	1edic	d			
Box 687	ending	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   1 □ Live Birth 2 □ Fetal death 3	☐ Ectopic pregnancy	4	23d. Date of delivery
B0)	death the att	sici		Other (specify)		Month Day Year
0	at the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
S, F	ires the signer of the control of th	d by	Altheiner's Denentia		1 ☐ Yes 2	□ No 3 □ Probably ✓ Unknown
ord	v requ	Completed			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
3ec	The lay	mo			autopsy performed? 1 ☐ Yes 20 No	death?
al	sian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Che		
Ξ	Physic this ce al dire	은	1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatie		lome 5 Residence 6	
n o	ding F. h. After funer	sate	Natural 5 Pending (Month, Day, Year) injury	of 28c, Injury at work?  M 1 \sum Yes 2 \sum No	28d. Ďescribe how injur	y occurred
Division of Vital Records, P.O.	Atten	Certificate:	2			nd Number or Rural Route Number,
Div	tal or rs afte al Dire		building, etc. (Specify)		City or Town, State,	<i>,</i>
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the best of my knowledge, death	stigation, in my opinion, death occurred	at the time, date and place	e, and due to the cause(s) and manner stated.
	o the ithin 2 the o the omple	Ž	only one) 3 Certifying Nurse Practioner: To the best of my knowledge.  29b. Signature and title of certifier	death occurred at the time, date and place 29c. License number		s) and manner as stated.  Ite signed (Month, Day, Year)
	/ N		puton ~	90048050	2/3	11/
	55h		30. Name and address of person who completed cause of death (Item 23a) (Type,		deen mo 7	1001
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	2.10 March		
	Registr		AUG 0 5 2011 Januar S. 19	arke		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 201 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death August 1, 2011 **Physician** 7:40 RM Richard Fred Townsend /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8810 Walther Blvd. Apt. 2327 Baltimore Parkville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) Apr 22, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) **Funeral** Year, Days Hours New York 1 M 2 F 91 Director 124-10-8698 1920 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show fraumatic event, the Medical Examinational be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Parkville filed within 72 hours after death with the Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd. Apt. 2327 21234 United States items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ō Specify: 3 Specify White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Westing House Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant; if item 27 is marked oth any injury or other traumatic event Be Fred John Townsend Gertrude Crowther 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Blanche Townsend /Wife 8810 Walther Blvd. Apt. 2327 Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Aug 03 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 4 Donation 5 DOther (Specify) 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives 401443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ubease or Figury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician; The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical nding p nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Por Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been si, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Vital 1 TYes 2 No 1 ☐ Yes 2 ☑ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA of this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 058646

State Registrar

DHMH 17 Rev 1/2001

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mondo

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Monias

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amend items 5.8 per fh g918 8-17-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 8:15 PM AUGUST 2011 MARY LEE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE FUTURECARE LOCHEARN If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 213-20-0403 Age (In yrs. last birthday) Funeral Days Months Hours 2-28-1921 90 NC Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 X Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 2501 Shirley Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Was Deceden Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. BLACK 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER HOME Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY LEE WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 SHIRLEY AVE. BALTIMORE, MD 21215 BERNARD WELLS / SON Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest 8/9/11 Owings Mills, MD 21. Jign ture of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. BALTIMORE. 1701 - 31LAURENS ST. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as call lac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final SCASC Physician/ MICONY disease or condition Medical resulting in death) Duy to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of than, leading to inneclate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day by the g Unknown P.O. | 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Completed by g 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 No death? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending М Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) icense numbe 33 08 03 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith VITE 203 SALTITIONE KARLEN W. MERNITT 2835 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

AUG 0 5 2011

## ₹ Pt. Known ad WATSON, YEGRESS

			For State Registrar		State	of Marylan	d / Depa <i>Cer</i>	artment of F tificate of D	lealth and I Death		giene 201	1 25025	
i	Physicia Medic		1. Decedent's Name Vergres	(First, Middle, I s Mae	watson					2. Date of Dea Month	Day Yea	1 1. 28 PM	
	Examin		4a. Facility Name (if r	HOSPIT	AL OF	BALTIM		**	Location of Death		4c. County of De	<sup>eath</sup> N/A	
	Funeral Director		5. Social Security Nu 214-72- Usual Residence of I	8377	Sex 1 □ M 2 🖾 F	7. Age (In yrs. 1	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.			Birthplace (State or Foreign Country) AL	
	Aaryland Ba-f show tified at	rector		10b. County N/A		10c. Cit Ba	y, Town or Local Ltimoi	eation		· · · · · ·		10d. Inside City Limits 1 □XYes 2 □ No	
	with the Ns 23a or 2	Funeral Director	10e. Street and Num 5322 De		Ave	<b>!</b>		10f. Zip Code 21215	5		10g. Citizen of What	Country?	
9600	e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted by Fun	11. Marital Status 1 Å Never Marrie 3 ☐ Widowed 4	I ☐ Divorced	Armed For 1 ☐ Yes If Yes, Giver Year or D	Armed Forces? 1 ☐ Yes ※☐ No			Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒No Specify:			mencan Indian, hite, etc. can ner.	
Baltimore, Maryland 21215-0036	vithin 72 ho piene. er than "nai the Medica	Completed by	(Special Special Speci		Education grade completed College (*		(Give k life. DC	ent's Usual Occupa ind of work done of NOT use retired) Homemake	luring most of wor	king	16b. Kind of Business Industry Self		
/land	should be filed within h and Mental Hygiene. 7 is marked other than raumatic event, the M	To Be	17. Father's Name (F James W						18. Mother's Nan Juanit	ne (First, Middle, I a Mille	Maiden Surname) E <b>T</b>		
, Mar	s 1 and 2 should be file of Health and Mental H If item 27 is marked o r other traumatic ever		19a. Informant's Nar Lorraine		(Type, Print) Daught	er	19b. Mailin	g Address (Street a 2 Denmo:	nd Number or Ru re Ave,	ral Route Number Balt., N	City or Town State, ID 21215		
timore	permit. Page 1 a Department of H Important: If ite any injury or ott		4 Donation	Cremation 3		State C	emetery, crem laney	sition (Name of latory or other place Valley	0,0		20c. Location - City Tim., MI		
Bal	permit Depar Impor any in		21. Signature of Fun	4	1						71027266	55905A	
	hysician/ Medical Examiner	er.	Immediate Cause (F disease or condition resulting in death)  Sequentially list con	t failure. List onl Final n nditions,	a. Due to	ach line. EVERE (or as a consequ NEUM(	SEP lence of): ONIA		g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death  day  day	
09	te be e. nysiciar ne buriż	dical Examine	if any, leading to impact of the cause. Litter of user Cause (Disease or it that initiated events resulting in death) Litter of the cause of the cau	ying injury	c	(or as a consequ							
	death certific	/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1  Yes 2  Y 9  Unknown	norths?	1 🔲 Live	nant at time of o	ldeath 3 🗀	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year		
ls, P.O.	requires that the de been signed by the should be detached	by	Part II. Other signific	cant conditions	contributing to c	death but not res	ulting in the u	nderlying cause giv	en in Part I.			to the cause of death?	
Division of Vital Records,	The law ate has page 2	Completed								24a. Was a autop perfor 1 \( \subseteq \text{ Yes} \)	sy prior t med?// death	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ No	
Vita	/sicia s certi directo	To Be	25. Was case referred examiner?  1 \sum Yes 2 \sum 4		Hospital:	Inpatient 2 🗆	ER/Outpation	Otho	ace of Death (Chec		ence 6 Other (Sp	anife)	
n of	iding Phys th. After this funeral di		27. Manner of Death 1 Natural 2 ☐ Accident	5 Pending	28a. Date (Mon		28b. Time of injury	28c. Injury work	at		ow injury occurred	еспу	
Divisio	Hospital or Attendi 24 hours after death. Funeral Director: A sted filled in by the fu	Certificate:	3 Suicide 4 Homicide	6 Could no determine	be 28e. Place	e of Injury - At ho ing, etc. (Specify			163 2 1110	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director.	Medical	(Check 2 l only one) 3 l	<ul> <li>Medical Exa</li> <li>Certifying N</li> </ul>	miner: On the ba	sis of examinatior	n and/or investi	gation, in my opinio eath occurred at the	n, death occurred a time, date and pla	at the time, date ar ace, and due to the	cause(s) and manner	ne cause(s) and manner stated. as stated.	
D	or wit		29b. Signature and ti	alux	inf				1404 I		29d. Date signed (Mo	nth, Day, Year)	
			30. Name and address	AKS+	IU BA	LWAN	, 51	NAI HO	SPITAL	OF BA	LTIMOR	E	
	Stat Registra		31. Date filed (Month,	G 0 5 20	11 Sent	Registrar's Signat	far.	4					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Month 07 Physician/ il: II AM Nina Mae Widzga Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAINT AGNES HOSPITAL if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number 216-34-0877 6 Sex **Funeral** Days Hours Country) 1 □ M 2 🏻 F 12711771935 MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Baltimore MD Baltimore 1 Yes 2 V No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21227 2113 Gaylawn Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 Yes 2XXNo White 3 😾 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturer Manufacturer Worker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Margarett Agnes Perry Louis Fink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Simon, son Baltimore, MD 21227 Gaylawn Dr. Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2011 Denver, CO Science Care 4X Donation 5 Other (Specify) & Cremation Svcs. 22. Name and Address of Facility Rapp Signature of Fune at Section e Licensee 2 Silver Spring, MD 20910 933 Gist Ave. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) HORTIC STENOSIS Medical Due to (or as a consequence of) Examiner SEPTIC SHOCK Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ISCHEMIC CARDIOMYOPATH the bunial-transit Hospital or Attending Physician: The law lequires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Completed by Physician/Medical LIVER FAILURE Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death cat has been signed by the cape 2 should be detached in 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 No. 1 ☐ Yes 2 ☐ No After this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 X No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

29a. Certifier

(Check

only one 29b. Signature and title of

EONARD

31. Date filed (Month, Day, Year) AUG 0 5 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sign

GLUFFREDA

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

900 SOUTH CATON AVE, BALTIMORE, MD

25907

29d. Date signed (Month. Day, Year) 31

FO

2011

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 25027 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:28 AM WOLFSON AUGUST 02, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8506 CHURCH LANE BALTIMORE RANDALLSTOWN If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 F Months 08/05/5011 Director 080-14-4622 89 10/06/1921 NY Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Funeral Director MD BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8506 CHURCH LANE 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify. Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **SECRETARY** INSURANCE marked other and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ JOSHUA CORNEY RACHEL BALL Baltimore, Mar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARL WOLFSON/SON 8434 DOGWOOD ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages permit. Pages
Department of
Important: If it
any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS CEM: 08/04/2011 OWINGS MILLS, MD 21. Signature of Fuperal Service Lio 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Self disease or condition resulting in death) /Medical Due to (or as a consequen of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). Physician: The law requires that the death certificate be execute the burial-tra resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Pay, Year) 28d. Describe how injury occurred 5eK28b. Time of Hospital or Attending Injury 1 ☐ Natural 5 Pending ours after death.

neral Director: / investigation 08/2/2011 0928A 1 🗆 Yes 2,**□**No Shotwork 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of weath (Item 23a) (Type, Print) TrimbleHill 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/  $20^{\text{Year}}$ 1.00p <sup>M</sup> Stephen Ames Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges 2809 Lumar Drive Fort Washington 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number If Under 1 Year 8. Date of Birth 6. Sex **Funeral** 1 M 2 🗆 F Months Days Hours (Month, Day) <sup>Year</sup> 950 Washington DC Director 579-64-5677 I hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 No Prince Georges Fort Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2809 Lumar Drive United States 20744 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 72 hours after Baltimore. Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 K No Specify: 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Montgomery County College (1-4 or 5+) Elementary/Seconday (0-12) traumatic event, the llth Truck Driver Government should be filed with h and Mental Hygien 7 is marked other ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Stephen Ames Sr. Reatha Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 2809 Lumar Drive Fort Washington MD 20744 Alma Ames/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date mation 3 Remo Lincoln Memorial 7-23-2011 Suitland, Maryland 4 Donation Other (Specify) eral Service 22. Name and Address of Facility John T. Rhines Funeral Home 21. Signature of Fa 3005 12th Street NE Washington DC 20017 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 1. Enter the disease, or complications that ock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician, Respiratory Failure Medical fing in death) Due to (or as a consequence of): Examiner COPD, Asthmatic Bronchitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) Pregnant at time of death signed by the aid be detached f 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Hospital or Attending Physician: The law requires Cardiomyopathy Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Diabetes has autonsy performed? death? certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 24 hours after death. Funeral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 🔀 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifi (Chec completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Sig and title of certif

State

5530 Wisconsin Avenue, Silver Spring, MD 20815 MD Mahmood Mohamadi, 32, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 22 Day Physician/ 2011 JULY 11:50 AM RICHARD BASIL BOWDEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CECIL ELKTON ELKTON CARE AND REHAB If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1**XX**M 2 □ F Months Days Hours JULY 13, 1924 Director 218-14-0692 87 Usual Residence of Decedent or 28a-f show e notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director Yes 2 No ELKTON MARYLAND CECIL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö ms 23a or must be r Funeral 21921 UNITED STATES 1 PRICE DRIVE ral", or items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? <sup>1</sup> √Yes 2XXNo 14. Race - American Indian 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: WHITE If Yes, Give Year or Dates Specify: "natural", Completed 3 X Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once. SHIP BUILDING 8 LABORER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ ADELINE VICTORIA WHYTE BASIL HAYNES BOWDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3431 WEST PULASKI HIGHWAY, NORTH EAST, MARYLAND 21901 <u> CATHERINE CORRON / DAUGHTER</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State JULY 30, 1 🛣 Burial 2 □ Cremation 3 □ Removal from St cemetery, crematory or other place, PANARAMA MEMORIAL GARDENS STRASBURG, VIRGINIA Donation 5 Other (Specify) 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. NORTH EAST, MARYLAND21901 127 SOUTH MAIN STREET, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alherosclerolic Heart Discase Unknown Phytician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions if any leading to in reaches cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 1 Yes 2 L 9 Unknown signed by the a d be detached f Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vnknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ this 27. Manner of Death 1 Natural filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred iniury 5 Pending after death. 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

3 🗆 29b. Signature and title of pertifier

Jackders m)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.S SACHDEV MD 126 A F. Hick

32. Registrar's

Baltimore, Maryland 21215-0036

29c. License number

e or death (item 23a) (type, Print) 126 A, E Hish ST, Elhtin MD 21921.

D0023322

29d. Date signed (Month, Day, Year)

7.22.2011.

State Registrar

Medical

29b. Signature ar

Thomas/

title\_ef\_certifier

McNamara, M.D.

10215 Fernwood Rd., Suite 100, Bethesda, MD 20817 31. Date files (Month, Day, Year) JUL 22 2011

30. Name and apdress of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D32610

29d. Date signed (Month, Day, Year)

July 18,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ 1:03 P M Ann Burger Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Williamsport Retirement Village Williamsport Washington Co Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 1 □ M 2**X** F Hours 218-24-2022 Dec. Maryland Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Washington Co. Williamsport 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral items 23a 21795 U.S.A. 154 Artizan Street death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No "natural", or þ Baltimore, Maryland 21215-0036 within 72 hours after 1 🗆 Yes 2 🏻 No If Yes, Give Specify: White 3 Widowed XX Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the 11-1 Elementary/Seconday (0-12) College (1-4 or 5+) Event Cordinator Country Club Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Percy Albert, Sr. Daisy Gruber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sheree Rauth / Daughter 7729 Stonevalley Drive Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park July 26,2011 Hagerstown, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21 From ture of Funeral Service License Eastern Blvd. N., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ 1272 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to or as a consequence of it any leading to immedi-cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transi and Due to (or as a consequence of) resulting in death) Last ttending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicia Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy
☐ Other (specify) \_\_\_\_ 3 in the past 12 months? signed by the 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown (ou )100 within 24 hours after death.

To the Funeral Director: After this certificate has been signompleted filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 500 ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 27. Manner of Death 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No М Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert

JW - Z

State 31. Date filed (Month, Day, Registrar

30. Name and addres

Shahid

Mahmord

580C Northern Ave

Hagerstown MD

ed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended Item 5 per F.D. 07/26/11 Carroll Co., will state of Maryland / Department of Health and Mental Hygiene [] 25032 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4:30 A M 07 2011 18 Charles Francis Barrett /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Carroll Emeritus at Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/07/1920 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number 246-07-5135 **Funeral** Days Months 1X M 2□F Yrs NC Director 246-07 90 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State r than "natural", or itams 23a or 28a-f shov the Medical Examinar must be notified at Y☐Yes 2☐No Director Westminster Carroll MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21157 45 Washington Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: þ White Year or Dates: WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Gov't. Affairs Advisor Journalist 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be iment of Health and Menta tant; if item 27 is marked Harry Lee Barrett Martha Queen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 431, Hillsboro, NM 88042 Charles Barrett/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Carroll Cremation 07/19/2011 Hampstead, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel 21. Sig lature of J neral Service Licensee 412 Washington Road, Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rmsms **Physician** a /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine -transit certificate be executed and physician ar s the burial-to Due to (or as a consequence of) Box 68760. Physician/Medical as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year fo in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death P.0. the detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown has been signed by Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 1 ☐ Yes 2 No certificate 25. Was case referred to medical funeral director, 26. Place of Death Check onl one 6 Other (Specify) examiner? Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. after death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) l in by 4 Homicide ŏ To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifit 29c. License number WJL 10+ address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and JA 10 mm W 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25033 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July George Olan Bollinger 2011 Medical 9:50 a 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 4/15/1933 Funeral 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1 X M 2 - F Months Days Hours Country) Director 220-26-6188 78 MD ms 23a or 28a-f shov must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Carroll Hampstead 1 🗌 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1611 St. Paul Street 21074 USA items 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Yes 2 No 1953 Yes, Give Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 
Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 12 I 17. Father's Name (First, Middle, Last) stone mason masonry Be 18. Mother's Name (First, Middle, Maiden Surname) ပ George Irvin Bollinger Elsie Fowble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Betty Bollinger, wife 1611 St. Paul St., Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or of 20c. Location - City or Town, State Page 1 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampstead Cemetery 7/19/2011 Hampstead, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eline Funeral Home Lemmer 934 S. Main St., Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LymptomA METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of Examiner YMPHOMA Sequentially list conditions, Examine Due to for as a consequience of cause. Enter Underlying Cause (Disease or iinjury burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical as the l IF FEMALE for use yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Vear the detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown een 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsv Hospital or Attending Physician: The performe death? this certificate 1 ☐ Yes 2 ☐ No 1 Yes PNo 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes A No Other: ပ ER/Outpatient 3 DOA Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending thin 24 hours after death.

the Funeral Director; Aimpleted filled in by the fu 1 Yes Accident Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying hurse Practioner: To the boat of my fromedge death or turned at the time, date and place, and due to the cause(s) and manner stated. (Check To the Ivitin 2. and title of centifie 29b. Signature 29d. Date signed (Month. Day, Year) WIL 00061755 7/15/2011 10+1VA and address of person who completed cause of death (Item 23a) (Type, Print) HEMALATHA NAGANNA POOLE DO WESTMINSTER, MD 700 A

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

Box 68760

P.O.

Records,

**Division of Vital** 

32.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25034 Registrar Amend#23aport1\_perPhys\_MFPCC7-22-11 Gertificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Month July Physician/ 1, 2011 Cathrine C. Brown aka Katherine Brown 4:25  $A^M$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George's Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 17, 1 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 🗆 M 2 🖾 F Country)
Maryland Days Months Hours Director Yrs. 577-40-0215 1919 Usual Residence of Decedent 28a-f shov 10a, State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Landover Maryland Prince George's ь 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20785 United States 7115 Flagstaff Street death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 hours after African 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced Completed American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 721 (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Government Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be ment of Health and Menta William Hadley Cathrine Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Louise D. Brown - Daughter 7115 Flagstaff Street Landover, Maryland 20785 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State July 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland Harmony 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service Licensee 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 3 months Physician/ disease or condition Recurrent Sepsis Medical resulting in death) Due to (or as a consequence of) Examiner 5 months Perforated Bowel spontaneous perforation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi). due to Colon wall deterioration Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the hirial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ g ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acute Renal Failure 1 Yes 2 No 3 Probably 4 X Unknown Completed has been Respiratory Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 X No After this certificate 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury **X**Natural 5 Pending work? 1 □ Yes 2 □ No Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature a 29c, License number 29d. Date signed (Month, Day, Year) 11 D 1673MD

Registrar
DHMH 17 Rev 7/2009

State

Sack

6130 Landover Road

32. Registra 's Signa

20785

Cheverly, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Revathy Murthy, MD

2 2 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		•	1 - State of Maryland / L Registrar	Department of Health and I Certificate of Death	vientai Hygier Reg.	2011	25035					
	Physicia		1. Decedent's Name (First, Middle, Last)  Christopher Lee Barnes		2. Date of Death 0 4 1 0 - 2	ტ√11 <sup>Year</sup>	3. Time of Death					
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	,					
	Funeral		Prince George's Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birt)	Cheverly  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	rince Ge	lano (Stata or Fornian					
	Director		212-13-1923   ¹X□ M 2□ F   25	Yrs. Months Days Hours Min.	0 7 <sup>Mo</sup> 11 <sup>h</sup> 0 <sup>Day</sup> ;1 <sup>Y</sup> 9	86 Coun	try) MD					
	and show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		1	0d. Inside City Limits					
	Maryl 28a-f notifie	Director	MD Prince George's Bowie				1 X Yes 2 □ No					
	with the 23a or	Funeral [	622 Jennings Mill Drive	10f. Zip Code 20721	US 10g.	Citizen of What Cour	itry?					
	death r items iner mu	, Fun	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ						
036	rs after ral", o Exami	ed by	1 Never Married 2 Narried 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 🏌 No Specify:		Specify: Blac						
15-0	72 hou n "natu ledical	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	sing 16b	. Kind of Business In	dustry					
212	within giene. ier thau		Elementary/Seconday (0-12) 1-4 College (1-4 or 5+) P	ife. DO NOT use retired) rogram Analyst	Pr	ivate Ir	ndustry					
land	l be filed lental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last) Donnie Barnes	18. Mother's Nan Sharon	ne (First, Middle, Maide Nazelrod	en Surname)						
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once.	7	19a. Informant's Name/Relationship (Type, Print) Kendra S. Barnes/wife 62	Mailing Address (Street and Number or Ru 2 Jennings Mill I	al Route Number, City Y., Bowie	or Town State Zio (	ode) 21					
ore,	ge 1 and of the it of the or othe		1 🗓 Burial 2 🗌 Cremation 3 🔲 Removal from State   cemeter	Disposition (Name of y, crematory or other place)	I	. Location - City or To						
altin	mit. Pa bartmer sortant r injury		4 ☐ Donation 5 ☐ Other (Specify) Cedar  21. Signature of Euneral Service Licensee	Hill Cem. 07-3	.9-2011 S	uitland,	20746					
m	an In Operation		Tisha X. Beid	Cedar Hill FH,43		e.,Suit	and, MD					
	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Asphyxiation		or respiratory arrest,		Approximate Interval Between Onset and Death					
	Medical Examiner		disease or condition resulting in death)  ASPNYXIATION  Due to (or as a consequence of									
4	-	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	scuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									
0	icate be executed g physician and s the burial-transit	edical E	d	.,,,								
68760	ertificate ding phy e as th		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy									
Box (	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day <b>Y</b> ear					
P.O.	requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobaco	o use contribute to the	e cause of death?					
rds,	equires een sig nould b				1 🗆 Yes		pably 4 🗌 Unknown					
eco	e law r e has b ige 2 sk	Completed			24a. Was an autopsy performed	prior to co	osy findings available mpletion of cause of					
Eal H	sician: The law I		25. Was case referred to medical examiner?	26. Place of Death (Chec		No 1 🗆 Yes	2 L No					
<u> </u>	Physic r this ceral dire	၉	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 X ER/Ou 27. Manner of Death 28a. Date of injury 28b. T		ome 5 Residence		nghimself					
ono	ending eath. or: Afte he fune	Certificate:	2 Accident Investigation 7-10-2011 15	njury work?	rom bani		- 1					
Division of Vital Records, P.O. Box	of the Hospital or Attending Physiciam: Within 24 hours after death To the Funeral Director. After this certification properties of the funeral director, it		3 $X$   Suicide 6   Could not be determined 28e. Place of Injury - At home, fare building, etc. (Specify) $ho$	m, street, factory, office <b>m</b> e	28f. Location (Street City or Town, Ste Mill Dr.	and Number or Rural ate) 622 Je Bowie N	Route Number, ennings ID 20721					
	e Hosp 24 hou e Funer	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, conduction of the desired forms and/or conduction of the desired forms and/or conduction of the desired forms and forms	r investigation, in my opinion, death occurred a	t the time, date and pla	ace, and due to the car	use(s) and manner stated.					
	To th withir To th comp		29b. Signature and title of certifier	29c, License number	29d. I	Date signed (Month,	Day, Year)					
			30. Name and address of person who completed cause of death (Item 23a) (1			July 2	0, 2011					
1	2		Salvador Sylvester 3011 Hos	pital Drive, Che	verly, MI	)						
	Stat Registra	٠ ۱	31. Date filed (Month, Day, Year) 32. Registry's Signature									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BOSTJANICE Physician/ RENE 2331 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours 10 18 7 Y 920 PENNSYLVANIA 163-20-0020 Director 90 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** 1 Yes 2 No MARYLAND QUEEN ANNE'S SUDLERSVILLE 10e. Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? 23a USA 21668 601 FOXXTOWN DRIVE, APT. 110 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ral", or iten Examiner i 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No e filed within 72 hours after dotal Hygiene. dother than "natural", or it 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced If Yes. Give Specify. Year or Dates WHITE traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ပ္ MARIANNA POPOWSKA FRANK GONSOWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 605 YAWL COURT, ANNAPOLIS, MD 21409 DONNA HUEBNER/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 4 Donation 5 Other (Specify) 07/22/2011 STEVENSVILLE, MD 21. Signature of Funeral Service Licenside 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS, HELFENBEIN & NEWNAM CREMATION TO THE PLANE BY BESTGATE ROAD, ANNAPOLIS, MD 21401 art 1. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onet and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes 2-No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should li 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy e Hospital or Attending Physician: The 124 hours after death.
9 Funeral Director: After this certificate I leted filled in by the funeral director, page performed 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the i only one) Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person who of death (Item 23a) (Type, Print) 360 5 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 17 ay July 2011 1 7:55 Ам Pierina Barbo Medical 4c. County of Death
Anne Arundel 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Heart Homes Annapolis 9. Birthplace (State or Foreign Italy) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 XF Months Hours 11/11/9/11/924 212-36-1959 87 **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Annapolis 1 Yes 2 X No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21401 2015 Vineyard Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No þ Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: Specify: If Yes, Give Completed 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annunziata Carretti ည Adelindo Ercolani 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $2015\ Vineyard\ Road,\ Annapolis,\ MD\ 21401$ 19a. Informant's Name/Relationship (Type, Print) Lucy L. Taylor - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
St Mary's Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 7/20/2011 Annapolis, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ATHERES CLEROTIC (EREBROVASCILL disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** FIBIZILLATIUM Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). DEMENTIA, Profound Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Be Completed by Physician/Medical DERMATOMYOSITIS Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Depression, Hypertension, Hypertin DEMIA 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? RECURRAL SKIN ULCERATIONS & CELLULITIS 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 24 hours after death.

Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 Matural Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Lecrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of certifier 29c. License number

State

JUL 2 1 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDRED GORDON MD 2003 MEDICAL PROY Suite 100 ANNARYE, MID 21401

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Michael Burns James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland Western Regional Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 MD Social Security Number 8. Date of Birth **Funeral** M 2 🗆 F Jun 4. 1930 Director 217-28-0516 81 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director notified Allegany Cumberland MD 1 X Yes 2 No ŏ 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be r Funeral USA 21502 One Baltimore Street Page 1 and 2 should be filed within 72 hours after death vacent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or item ledical Examiner r 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 X Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 □ Yes 2 No If Yes Give white 3 Widowed 4 Divorced Completed Year or Dates other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Catholic Church Priest Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Grace Martin James Hugh Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code)
1140 Newfield Road Gwynnoak
21207 Maureen Kelly Cousin Department of Health Important: If item 2 any injury or other t 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Sulpician Cemetery 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify) 8-1-2011 MD Catsonsville 21. Signature Funeral S 22. Name ar Scarpen Furieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause in each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter t Immediate Cause (Final disease or condition Ph<sub>sician</sub>/ 125476 10 Medical resulting in death) Examiner Sequentially list conditions, Due to for as a consequence of, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year Dav Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by the period of the sign of the si Be Completed by 1 Yes 2 No 3 Probably 4 Onknown cate has been sig page 2 should b 24h Were autonsy findings available 24a. Was an prior to completion of cause of death? autopsy performed' 2 No 1 Yes 2 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

certificate l this After 1 after death Director: A d in by the f hin 24 hours af the Funeral Di npleted filled ir within 2

To the I

comple

138M

Registrar

Certificate:

Medical

State

27. Manner of Death

1 Natural

Accident
Suicide

AUG 0 5 2011

4 Homicide

29a. Certifier (Check

5 Pending

Investigation 6 Could not be

determined

who completed cause of death (Item 23a) (Type, Print) Tramac nal

28a. Date of injury (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Seton Drive, Cumberland, MO, 21502

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

11-05601 Urie Brice

Street and Number   10c. City, Town or Location   10c. City, Tow	Birthplace (State or reign Country) MD  10d. Inside City Limits 1 Yes 2 No Country?  merican Indian, Black, c. White
4a. Facility Name (if not institution, give street and number) 9 Fairfield Avenue  5. Social Security Number 218-24-6115 1 Mm 2 F 81  Vrs. Months Days Hours Min.  5. Social Security Number 218-24-6115 1 Mm 2 F 81  Vrs. Months Days Hours Min.  6. Date of Birth(MM/DD/YYYY) 9. Oct 18 1929  For the part of th	Birthplace (State or reign Country) MD  10d. Inside City Limits 1 Yes 2 No Country?  merican Indian, Black, c. White
Social Security Number   Social Security Number   Social Security Number   218-24-6115   1	reign Country) MD  10d. Inside City Limits 1 Yes 2 No Country?  merican Indian, Black, c.  White
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Earleville  10a. State 10b. County 10c. City, Town or Location Earleville  10c. Street and Number 9 Fairfield Ave.  11. Marital Status 1 Never Married 1 Never	1 Yes 2 No Country?  merican Indian, Black, c.  White
MD Cecil Farleville    Mode   Company   Compan	1 Yes 2 No Country?  merican Indian, Black, c.  White
The state of the s	merican Indian, Black, c. White
The state of the s	white
20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  21con Cemetery  22c. Location - City crematory or other place)  21con Cemetery  22c. Location - City crematory or other place)  22d. Name and Address of Facility Callena Funeral Home of Stephen L.	
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21. Signature of Fungal Register Stephen L.	
1100510   110 West Closs St. Galetta, Inc. 210	535
Physician  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease a Intraoral Shotgun Wound	Approximate Interval Between Onset and Death
or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	
if eny, leading to immediate Due to (or as a consequence of):  Cause. Enter Underlying Cause  Unserse or prover that underlying	
events resulting in death) Last  Due to (or as a consequence of):  d.	
d.  UNPENDED  AMENDED  IF FEMALE:  23c. If yes, outcome of pregnancy  23d. Date of deliv	NADY.
So the second of	Day Year
The state of the s	
24a. Was an autopsy performed?	
1 V Yes 2 No 1 V  25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 V	other Scene
1   Yes 2   No   No   No   No   No   No   No	
Subject shot self    Town   Pending   Pending	
29a. Certifier (Check only one) 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a constant of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a constant of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a constant of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a constant of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a constant of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a constant of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a constant of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a constant of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a constant of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a constant of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a constant of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place are also as a con	stated. o the cause(s)
296. Signature and title of certifier  296. Electise fluitible  297. Libertse fluitible  298. Signature and title of certifier  298. Signature and title of certifier  298. Signature and title of certifier	(Month, Dav. Year)
30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State 31. Date filed (Month, Day Year) 32. Registrar's Stinature Registrar ALIG 0 5 201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JULY 2011 JOSEPH JOHN CLAUSIUS 06:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UNION HOSPITAL OF CECIL COUNTY CECIL ELKTON Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign TAMAANI)A PENNSYLVANIA **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) SEPT. 8.1922 1 **X** M 2 □ F Days Hours Months Min Director 191-12-7393 88 Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ី No MARYLAND CECII RISING SUN 6 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 964 EBENEZER CHURCH ROAD UNITED STATES 21911 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 9 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes. Give WHITE Specify: 3 😾 Widowed 4 🗆 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) EOUIPMENT OPERATOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CONRAD J. CLAUSIUS / SON 964 EBENEZER CHURCH ROAD, RISING SUN, MARYLAND21911 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) JULY<sub>1</sub>26, UNION CEMETERY ELKTON, MARYLAND 21. Signatur - of Fungal/Servi e Licersee 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, taply one cause on each line. 23. Part 1. Enter the disease Approximate shock, or heart failure. List Interval Between Onset and Death Immediate Cause (Final Physicianz disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner all Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine the attending physician and hed for use as the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur DORUMONO Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death g Unknown 9 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending (Month, Day, Year) injury 1 Natural M Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nion

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 24a per verb 2918 8-5 Health and Mental Hygiene

			State Registrar		Cer	tificate of Dea	ath		Reg. No. UII	25041			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	th Day Year	3. Time of Death			
	Medic	al	Edna Eleanora I  4a. Facility Name (if not institution, give s			4b. City, Town, or Loc	cation of Death	JULY	27, 2011 4c. County of Dea	11:23 AM			
_	Examin	er	Meritus Medical Co			Hagersto			Washi				
	Funeral Director		5. Social Security Number 6. Sex 1 212-58-7633	7. Age (In yrs	s. last birthday) Yrs.		Under 24 Hrs. lours Min.	8. Date of Birtle Month, Day 5/22/19	9. Bi	rthplace (State or Foreign ountry) nsylvania			
	100		Usual Residence of Decedent					J   44   1 J	17   1611				
	aryland a-f she fied at	Director	10a. State 10b. County		City, Town or Loc					10d. Inside City Limits 1  Yes 2 No			
	the Mi or 28 se noti		MD Washingto	on Hay	gerstown	10f. Zip Code			10g. Citizen of What C				
	th with ns 23a must k	Funeral	13006 Salem Avenue		T.	21740			U.S.A.				
တ	er dea' or iter niner	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	<ol> <li>Was Decedent Ever in U Armed Forces?</li> <li>1 ☐ Yes 2 No</li> </ol>	<b>I</b>	Vas Decedent of Hispar Yes, specify Cuban, M		ican, etc.)	14. Race - Am Black, Whi				
800	urs aft tural", al Exar	ted k	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates.		Yes 2 No S			Specify: Wh	ite			
15	72 ho in "nat Medica	Be Completed	15. Decedent's Edu (Specify only highest grad	de completed)	(Give k	ent's Usual Occupation ind of work done durin O NOT use retired)	n ng most of working	g	16b. Kind of Business	s Industry			
212	withir giene Jer tha t, the	ပ္ပ	Elementary/Seconday (0-12)	College (1-4 or 5+)	Нс	memaker				Domestic			
and	oe filed intal Hy ced ott	To B	17. Father's Name (First, Middle, Last)  William Smith Be	eeler		18.	Etta B		Maiden Surname) <b>Leger</b>				
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Typ	. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number									
ω ω	and 2 s Health s em 27 i		Ronald Dietrich ,										
nor	age 1 a ent of h		1 ■ Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify)	Removal from State		natory or other place)		/2011	20c. Location - City o				
Baltimore,	permit, Page Department of Important: If any injury or once.		21. Signature of Emeral Service License			Name and Address of			Hagerstown en Funeral				
<u> </u>			23a. Part 1. Enter the disease, or compl	1. Beall					lagerstown,				
	Physician/		shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.		r the mode of dying, st	uch as cardiac or	respiratory arr	est,	Approximate Interval Between Onset and Death			
	Medical		disease or condition resulting in death)	a. Due to (o/a) a conse	aduance off:		0			When irmalis			
	Examiner	ie i	Sequentially list conditions,	b. Diverticed	letis h	un Reite	bleidin	1		1-2 DAYS			
	ited d unsit	amin	ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Devente	нциенсе оп.		(	U		- Years.			
	ificate be executed ig physician and as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	Due to (or as a conse	equence of):								
8760	cate be physic s the bu	edic		d									
9	tifi as												
~	endi endi		23D. Was decedent pregnant		23b. Was decedent pregnant 23c. If yes, outcome of pregnand doubted in the programment of pregnand doubted in the pregnand doubted doubted in the pregnand doubted doubted in the pregnand doubted d								
Box	e death cer the attendi hed for use				etal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year			
P.O. Box	that the death cerned by the attendi	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	1 Live Birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3 of death 5	Other (specify)	in Part I.	23e. Did to		Day Year			
ds, P.O. Box	quires that the death cer sen signed by the attendi buld be detached for use	by Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3 of death 5	Other (specify)	in Part I.		Month  bacco use contribute t	Day Year			
ecords, P.O. Box	law requires that the death cer has been signed by the attendi pe 2 should be detached for use	by Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3 of death 5	Other (specify)	in Part I.	1 🗆 '	Month  bbacco use contribute telescope an 24b. Were a prior telescope and an 24b.	Day Year to the cause of death? Probably 4 Unknown utopsy findings available			
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n of Vital Records, P.O. Box	ding Physician: The law requires that the death cer. Th. After this certificate has been signed by the attendifuneral director, page 2 should be detached for use	To Be Completed by Physician/P	23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions con  25. Was case referred to medical examiner? 1   Yes 2   No   H	1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown  ntributing to death but not r	etal death 3	26. Place t 3 □ DOA  28c. Injury at work?	of Death (Check  United States of Death (Check States of Death (Chec	24a. Was autor performent of Resident R	Month  bbacco use contribute to the second s	Day Year to the cause of death? Probably 4 Unknown utopsy findings available completion of cause of			
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Division of Vital Records, P.O. Box	ne Hospital or Attending Physician: The law requires that the death on 124 hours after death.  In Euneral Director: After this certificate has been signed by the attendisted filled in by the funeral director, page 2 should be detached for use	Certificate: To Be Completed by Physician/I	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions con  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural 5   Pending 2   Accident   Investigation 3   Suicide   Accident   Acciden	1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown  Intributing to death but not re  lospital: 1 Inpatient 2 2 28a. Date of injury (Month, Day, Year)  28e. Place of Injury - At building, etc. (Specialization: To the best of my known in the second s	etal death 3 of death 5 of death 28b. Time of injury on the death 28b. Time of injury on death 28b. Time o	26. Place t 3 DOA Other: 28c. Injury at work? M 1 Yes Det, factory, office	of Death (Check 4 Nursing Hon 2 2 No 2 No 2	24a. Was autor performed to the cather time, date a the time, date a	Month  bbacco use contribute to the state of	Day Year  to the cause of death?  Probably 4 Unknown  utopsy findings available o completion of cause of es 2 No  ecify)  ural Route Number,  tated. e cause(s) and manner stated.			
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/P	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions con  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural 5   Pending 2   Accident   Investigation 3   Suicide   Accident   Acciden	1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown  ntributing to death but not r  lospital: 1 Inpatient 2 2 28a. Date of injury (Month, Day, Year)  28e. Place of Injury - At building, etc. (Specialization of the basis of examination of the basis of exami	etal death 3 of death 5 of death 28b. Time of injury on the death 28b. Time of injury on death 28b. Time o	26. Place t 3 DOA Other: 28c. Injury at work? M 1 Yes Det, factory, office	of Death (Check)  4 Nursing Hon 2 2 2 No 2 te and place, and death occurred at the ne, date and place imber	24a. Was autoperforment of the control of the case of	Month  bbacco use contribute to the state of	Day Year  to the cause of death?  Probably 4 Unknown  utopsy findings available completion of cause of es 2 No  ecify)  ural Route Number,  tated. e cause(s) and manner stated. eth, Day, Year)			
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Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death cenwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendicompleted filled in by the funeral director, page 2 should be detached for use	Certificate: To Be Completed by Physician/I	23b. Was decedent pregnant in the past 12 months?  1	1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown  Intributing to death but not re  1 Inpatient 2 28a. Date of injury (Month, Day, Year)  28e. Place of Injury - At building, etc. (Specials: To the best of my known or the basis of examinate e Practioner: To the best of	resulting in the understand death 5 resulting in the understand resulting in the understand resulting in the understand resulting in the understand resulting resultin	26. Place t 3 DOA Other: 28c. Injury at work? 1 Yes et, factory, office	of Death (Check:  4 Nursing Hon  2  3 2 No  2  te and place, and death occurred at 1  ne, date and place  mber	24a. Was autoperforment of the control of the case of	Month  bbacco use contribute to the contribute t	Day Year  to the cause of death?  Probably 4 Unknown  utopsy findings available completion of cause of es 2 No  ecify)  ural Route Number,  tated. e cause(s) and manner stated. eth, Day, Year)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John Austin DODDS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 16607 Tammany Lane Williamsport . Sex 1 **X** M 2 □ F 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Sept. 19 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Under 1 Year **Funeral** Wash. D.C. 67 1943 Director 550-56-8600 Sept. Usual Residence of Decedent 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No Washington Williamsport Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21795 USA 16607 Tammany Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian other traumatic event, the Medical Examiner Black, White, etc 01 1 Never Married 2 Married þ Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. Government Elementary/Seconday (0-12) College (1-4 or 5+) Commerce Department Statistician/Economist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elda Marion Libke John Emmerson Dodds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Columbia Road, Hagerstown, Maryland 21742 John Adam Dodds - Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Hagerstown Crematory 7/27/2011 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fundam Service License 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Squamous POLA Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) 1 Yes 2 9 Unknown the a detached 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Yes итет tnis certificate has been si funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pending death. To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completed filled in by the fu Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) M completed cause of death (Item 23a) (Type, Print)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death . 2011 Physician/ P MVienna Dudley July. 11 7:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Center Examiner Ft. Washington Health/Rehabilitation Prince George's Washington 9. Birthplace (State or Foreign Year If Under 24 Hrs. 5. Social Security Number If Under 8. Date of Birth 6. Sex Age (In yrs. last birthday, **Funeral** 1 □ M 2 🏋 F Days Hours (Month, Day, Year, une 23. Country) Months Min Yrs. Director 578-36-1258 1923 South Carolina June Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertlal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🙀 Yes 2 □ No Oxon Hill Prince George's Maryland | 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral United States 20745 # 102 6275 Oxon Hill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. à 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Food Service Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Villard Lee Corley Mattie June Harris 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6275 Oxon Hill Road # 102 Oxon Hill, Md. 20745 Patrice A. Dudley-Zogdoule -20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State July<sub>0</sub>19, Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 21. Signature of Fun ra Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Arteriostic Heart Disease Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence of, Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Day Year Pregnant at time of death Unknown ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 🗶 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🔀 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔁 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Director: / 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours a Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

William Tanner M.D.

31. Date filed (Month, Day)

D35206

11701 Livington Road Fort Washington, Maryland

July 14, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25044 State of Maryland / Department of Health and Mental Hygiene [] for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ July 2011 Alexis Hankins Duncan 27 2:35P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 2446 Island Branch Road White Hall 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏲 F Months Days Hours Min. Apr. 25 Year 1947 Director 213-58-1564 64 MD Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Harford White Hall MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2446 Island Branch Road 21161 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Circut Court Clerk County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Grat B. Hankins Stella F. Mister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2446 Island Branch Rd. White Hall, MD 21161 Everett A. Duncan/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Aug. Cremation Direct Service 1 ☐ Burial 2X Cremation 3X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) York, PA 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JJ Hartenstein Mortuary, Inc. 19 S. Main Street, Stewartstown, PA 17363 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant 9 Unknown 5 Other (specify) Year Pregnant at time of death Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Medical Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident injury 1 ☐ Yes 2 ☐ No Investigation

Division of Vital Records, P.O. Box 68760

1102/12

within 24 hours after death.

To the Funeral Director: After this certificate has been signed to completed filled in by the funeral director, page 2 should be detential.

3 ☐ Suicide € 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, fabuilding, etc. (Specify)	actory, office		(Street and Number or Rural Route Number, wn, State)
(Check 2	Medical Examiner	an: To the best of my knowledge, death occur r: On the basis of examination and/or investigation Practioner: To the best of my knowledge, death	on, in my opinion, death occurred	at the time, date	and place, and due to the cause(s) and manner state
29b. Signature and title of certifer			29c. License number		29d. Date signed (Month, Day, Year)

State Registrar

ath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepen Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 3:55 Bernice Emily 2011 Evans July 19. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Montgomery 600 Forest Glen Road Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 1913 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) ΊL 97 335-05-8079 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 Yes 2 No Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20901 USA 600 Forest Glen Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No SpecifWhite 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Technician HIID 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mae Neely John T. Jaeger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 215 Opal Drive, Chambersburg, PA 17202 Harold Bruce Evans/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition July 25 2011 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens a 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring,MD 20901 23a. Part f. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1ears disease or condition resulting in death) oronary Due to (or as a cons-uence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐ Pregnant at time of death 5 Other (specify) Yes a∏ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?' Yes 2 No

**Physician** /Medical **Examiner** The law requires that the death certificate be executed and

**Physician** 

**Examiner** 

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it e Madical Examinar must be notified at

items 23a

the Maryland

death with

Pages 1 and 2 should be filed within 72 hours after

and Mental !

permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 Is any injury or othar trau once.

Baltimore, Maryland 21215-0036

/Medical

Examiner the burne physician Physiclan/Medlcal SS esn signed by the a d be detached f þ Completed page Be Certification; filled in by

Division of Vital Records, P.O. Box 68760,

Hospital or Attanding Physician:

ithin 24 hours a o the Funaral [

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 ☐ Yes 2 No Manper of Death Natural 5 Pending

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) investigation

and manner stated

Other: 4 Nursing Home 5 esidence 6 Other (Specify) 28b. Time of

1 ☐ Yes 2 ☐ No

28d. Discribe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2 Accident

3 Suicide

4 Homicide

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print loms atricia

Pike, G-100

State Registrar

Medical

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $13^{\text{Day}}$ July Physician/ 12:00<sup>AM</sup> James Joseph Freeman 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Carriage Hill of Bethesda Bethesda 8. Date of Birth (Month, Day, Dec 29 9. Birthplace (State or Foreign Country)
Pennsylvania . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 🛣 M 2 🗆 F Dec. 578-54-6917 Director 70 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important, If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d, Inside City Limits 10a. State 10c. City, Town or Location Director Md Montgomery Bethesda 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5015 Sentinel Drive Apt. 83 20816 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ð 1 Never Married 2 X Married 1 ☐ Yes 2 🛛 No Specify: White Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Communications Law Attorney Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Robert Louis Freeman Ruth Steltz 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5015 Sentinel Drive Apt. 83
Bethesda, Maryland 20816 19a. Informant's Name/Relationship (Type, Print) Carol Freeman/ Spouse Baltimore, 20b. Place of Disposition (Name of cemeter), crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition July 14, 20c. Location - City or Town, State 1 🗆 Burial 2 🗵 Cremation 3 🗆 Removal from State Alexandria, Virginia 4 Donation 5 Other (Specify) M00215 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 2222 Wisconsin Ave., N.W. Washington, D.C. 20007 23a. Part 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death MULTIFOCAL CEUKDENCE Immediate Cause (Final PROGRESSIVE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying pue to for as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-treet. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 🗌 Yes 2 🕅 o Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗗 No 1 Inpatient 2 ER/Outpatient 3 DOA ည Manner of Death

Natural

Accident 28c. Injury at work? 1. ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Ber, MD

00057124

29d. Date signed (Month, Day, Year)

7/20111

Please	Type or	Print in	Black	Indelible	lnk.	Ensure	All	Copies	Are	Leg	jib	le
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		•	1- For State Registrar C6	ertificate of Death	Reg.				
	Physicia	in/	Decedent's Name (First, Middle, Last)     SARAJANE KITCHIN FINKENSTAEDT		2. Date of Death Month	Day Year 10:47 PM			
39734	Medic Examin	al	SARAJANE KITCHIN FINKENSTAEDT  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July 14	2011 10:47 PM 4c. County of Death			
ار	Examin	er	Shady Grove Adventist Hospital	Rockville		Montgomery			
	Funeral Director		5. Social Security Number	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth Mar • 7, 1	9. Birthplace (State or Foreign Country) Washington D.C.			
	nd show at	'n	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I		<u> </u>	10d. Inside City Limits			
	Maryla 28a-f s etified	Director	Maryland Montgomery Clarksh	urg		1 ☐ Yes 2 🔀 No			
	with the ls 23a or 2	Funeral Di	13120 Cool Brook Lane	10f. Zip Code 20871		Citizen of What Country?			
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes, 2 No If Yes, Give Year or Dates.	. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 🏋 No Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
15-(	72 hou n "nati ledica	nplet	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	g 16	16b. Kind of Business Industry			
212	vithin liene. sr thar the M			cial Worker	N	Tursing Home			
land ?	l be filed v fental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Mills Kitchin	18. Mother's Name (		den Sumame)			
Maryland	d 2 should alth and Iv 1 27 is ma er traumai		19a. Informant's Name/Relationship (Type, Print)  Frederick B. Finkenstaedt (Son) 2041	iling Address (Street and Number or Rural I .1 Apple Harvest Cir	Route Number, Cit	y or Town, State, Zip Code) Germantown, MD 20876			
Baltimore,	Page 1 an nent of He ant: If iten ury or othe			position (Name of ematory or other place) Litan Crem.  July 2011		c. Location - City or Town, State			
Balt	permit. Departr Imports any inji	}	21. Signature of Funeral Service Licensee M00215	al Home ashington D.C. 20007					
	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   RESPIRATORY FAI  Due to (or as a consequence of):	LUXE	respirator, arrest,	Approximate Interval Between Onset and Death			
	Examiner		SE0516	/mg) D.	2011	All DAYS			
	= ±0	Examiner	if any, leading to immediate Due to (or as a consequence of):	- A					
	and	xan	that initiated events resulting in death) Last c. EMPYEMA OF LEI Due to (or as a consequence of):	-T LUNG		WEEKS			
09/	cate be ex physician the burial	Medical		MALPLACEMENT OF I	NASOGAST	RIC TUBE 4 WEEKS			
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trinsit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year			
s, P.O.	es that the signed by be detain		Part II. Other significant conditions contributing to death but not resulting in the LEFT HIP FRACTURE DEMENTION	*		cco use contribute to the cause of death?			
Division of Vital Records,	law requir has been ge 2 should	Completed by	HYPERTENSION ACUTE REN		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
E R	an: The lifficate or, pag	Be Co	25. Was case referred to medical	26. Place of Death (Check of	performe 1 Ves 2	No. 1 ☐ Yes 2 💆 No			
Vit.	hysicia his cer I direc	To B	examiner? 1 X Yes 2 No Hospital: 1 X Inpatient 2 ER/Outpat			se 6 Other (Specify)			
ηof	ding Pl T. After tl funera	ate:	27. Manner of Death  1 Natural 5 Pending  28a. Date of injury (Month, Day, Year)  28b. Time (Month, Day, Year)	work?	8d. Describe how NALPLACEN	MENTOF NASOGASTICE			
isio	Attencer death	Certificate:	2 X Accident 3 Suicide 4 Homicide    Investigation   Could not be determined   Could not be determined   Could not be building, etc. (Specify)   Could not be building	street, factory, office 2	8f. Location (Stree	TUBE et and Number or Rural Route Number, or State) 9901 MEDICAL CENTER DR			
Ö	oital or ors aft oral Dia	Sal	SHADY GROVE ADVE		ROCKVIL	LE MARYLAND 20850			
	e Hosp 124 ho e Fune eleted f	Medical	29a. Certifier (Check only one)  1	estigation, in my opinion, death occurred at t	the time, date and p	place, and due to the cause(s) and manner stated.			
		-	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)			
	10		Muy	D65132	J	ULY 15, 2011			
			30. Name and address of person who completed cause of death (Item 23a) (Type WE) ZHANG MD 9901 MEDICAL CENTE		MARVIA	UN 20850			
	Sta	te	31. Date filed (Month, Day, Year) 82. Registrar's Signature	DRIVE ROCKVICES,	- IFFE COTT	-3040			
	Registr		JUL 22 2011 Lender B. 40						

1-05576 arry Foster		Please Type or Prin State of Ma	t in Black Indeli				e.					
		I- For State Registrar		ate of Death		Reg. No	2011	2501				
Physici Medical Exami	an/ ner	1. Decedent's Name (First, Middle,Last)  Larry George Foste			Mon July	26, 2011	Year	0535 hrs				
		4a. Facility Name (if not institution, give street an Johns Hopkins Bayview Medical C		4b. City, Town, or L Baltimore			c. County of Death					
Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. last birth	nday) If Under 1 Year Months Days		te of Birth (MM / 21 / 19	Eorgian	place (State or ntry) VA				
Maryland 28a-f show any d at once.		Usual Residence of Decedent 10a. State 10b. County VA Henrico	10c. City, Town			1100 0	1	10d. Inside City Limits 1 Yes 2 X No				
death with the Maryland or items 23a or 28a-f sho must be notified at once	Dire	3710 Whitlock Ave.		23223		US	SA					
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once	by Funeral	1 Never Married 2 Married Armo	Decedent Ever in U.S. ed Forces? es 2 X No e Yeer	13. Was Decedent of Hisp If Yes, specify Cuban,  1 Yes 2 No	Mexican, Puerto Rican,	etc.)	14. Race - America White, etc. Specify: Bla	ck				
11215-0036 Id be filed within 72 hours after fental Hygiene. sarked other than "natural", event, the Medical Examine.	Completed t	15. Decedent's Education (Specify only highest	ge (1-4 or 5+)	Decedent's Usual Docupation during most of working life.	DO NOT use retired)		Kind of Business/Ind	dustry				
21215-0036 21215-0036 July be filed within 7 Mental Hygiene. marked other than to event, the Medica	Be Com	17. Father's Name (First, Middle, Last) George Foster		1:	8.Mother's Name (First, N Bertha Kn	ight	1000					
MD 21 nd 2 should in the and Mee m 27 is man		19a. Informant's Name/Relationship (Type, Print Louise Foster/ Sis	ster 3	o. Mailing Address (Street 3710 Whitlo of Disposition (Name of cem	ck Ave. R	ichmo		23223				
Baltimore, MD 2's permit. Pages I and 2 should Department of Health and Mol Important: If item 27 is mainlury or other traumatic er		1 ABurial 2 Cremation 3 Removal from State Oakwood Cemetery 8/01/2011 Richmond, 4 Donation 5 Other Specify: 21. Signature of Funeral Sepvice Acensee 22. Name and Address of Facility Chiles Funeral Hom										
Physician	Y	Say Part Enter the Sease, or complications the	PL TO ME nat caused the death. Do no	2100 Fair	mount Ave	.Rich	mond Vir	ginia2321 Approximate Interval				
/Medical Examiner		failure. List only ne cause on each line.  Immediate Cause (Final disease a. Hyper	tensive Athe					Between Onset and Death				
	liner	cause. Enter Underlying Cause	as a consequence of):									
executed an and al - transit	al Examiner	events resulting in death) Last  Due to (or	as a consequence of):					2.1				
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Sox 68760, leath certificate be execut e attending physician and for use as the burial - tra	Physician/Medica	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnancy ive birth  regnant at time of death 5	=	Ectopic pregnancy		3d. Date of delivery Month Da	ay Year				
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Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death certificate be ours after death.  neral Director: After this certificate has been signed by the attending physici filled in by the funeral director, page 2 should be detached for use as the buri.	Completed by	Attioventificatal	ilvarar bibea	se, obcorey		a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of				
E T		25. Was case referred to medical			of Death (Check only one							
Vita hysicia this ce	To Be	examiner?  1 Yes 2 No Hospital: 1	Inpatient 2 🗹 ER/0		Other Nursing Home		dence 6 Other:					
Sion of Attending P death. ector: After		1 X Natural 5 Pending 2 Accident Investigation	Month, Day, Year)	1 Y	es 2 No		njury occurred					
<u> </u>	Certification:	Suicide Could not be determined (Spe			or	Town, State)		al Route Number, City				
To the Hospital within 24 hours To the Funeral completely filled	Medical		e best of my knowledge, dea asis of examination and/or in ner stated.	nvestigation, in my opinion,	death occurred at the tin	ne, date and p	place, and due to the	cause(s)				
	Σ	29b. Signature and title of certifier	Deck	29c. License O.C.M			I. Date signed (Mon ly 27, 2011	ш, <i>D</i> ау, теаг)				
12	J.	<ol> <li>Name and address of person who completed Victor Weedn MD JD Assistant</li> </ol>		900 W. Baltimore St	treet, Baltimore, Mi	D 21223						

3

Registrar DHMH 17 Rev 1/2001 OCME 2006

State

31. Date filed (Month, Day, Year) AUG 0 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death `**07/11%2011**\ear **Physician** L:07 A M James Lee Fitzgerald, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Villa Rosa Nursing Home Mitchellville prince Georges If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F VA 228-40-6002 78 Director 04/25/1933 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene. In the Maryland wit: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1XYes 2 No Director MD Prince Georges Ft. Washington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20744 AZU 6801 Bock Rd. apt.442 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🍎 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Black Š 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Safeway Clerk Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sallie A. Dixon ဥ Sammie Toy Fitzgerald, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6801 Bock Rd. apt.442, Ft. Washington, MD 20744 Erma L. Fitzgerald / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Lincoln Cemetery 67/19/20/1 Brentwood, MD 4 Dopation 5 Other (Specify) Ft. 21. Sign ture 22. Name and Address of Facility Strickland Funeral Services Funeral S 6500 Allentown Rd., Camp Springs, MD 20748 23a. Fart1. Enter the disease, or complications that shock, or heart failure. List only one cause of aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician ucarda hps resulting in death) Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending I IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 | Johnnown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 10 1 Inpatient 2 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Baltimore, Maryland 21215-0036

the death certificate be executed

Division or Vital Records, P.O. Box 68760,

The law requires that

State

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person wh

29b. Signature and

completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

7/15/11 1340 Baltimore, Maryland 21215-0036 JOHN PAUL GILLETTE

			Plea	ase Type or Pri	nt in Black aryland / D							ible.	25050
		-	For State Registrar	Otate of W		Certificate					Z U g. No.	1	23030
	Physicia Medic		1. Decedent's Name (First, Middle John Paul							Date of Death	Day	Year	3. Time of Death 1:05P M
	Examin		4a. Facility Name (if not institution Shady Grove Ad		ital		Town, or <b>kvil</b>	Location of	Death		4c. County Montg		
	Funeral		5. Social Security Number		e (In yrs. last birthe		r 1 Year Days	If Under 2 Hours	24 Hrs. 8. 6 Min. 25 Ju	Date of Birth Month, Day, Y		g. Birtl	nplace (State or Foreign intry) yland
	Director >		None Usual Residence of Decedent				L		23 pu	1y 1J,	2011	riai	
	aryland a-f sho fied at	Director	10a. State 10b. County West		10c. City, Town		**						10d. Inside City Limits 1 ☐ Yes 2 😾 No
	or 28s	Dir	Virginia   Jeff	erson	патре	rs Ferr	7			10	g. Citizen of	What Co	untry?
	s 23a nust b	Funeral	47 Jasmine P	lace			2542				ited S	tate	s of America
	r death ir item iner m	y Fur	11. Marital Status 1 ☑ Never Married 2 ☐ Ma	12. Was Decedent Armed Forces? rried 1 ☐ Yes 2 X	Ever in U.S.	13. Was Deced If Yes, spec	dent of Hi cify Cuba	ispanic Orig in, Mexican,	in? (Specify ` Puerto Ricar	Yes or No- n, etc.)		e - Amer ck, White	ican Indian, , etc.
21215-0036	rs after rral", o Exam	ed by	3 Widowed 4 Divorced	If Voc Civo	INO	1 🗌 Yes	2 <b>X</b> ) No	Specify:			Specify	· Ca	ucasian
15-0	"2 hour "natu edical	Completed		ent's Education lest grade completed)		Decedent's Usu Give kind of wo	rk done d	ation during most	of working	1	6b. Kind of B	usiness I	ndustry
212	vithin 7 iene. r than the M		Elementary/Seconday (0-12)	College (1-4 or	5+)	fe. DO NOT use Non	,				None		
	filed v d othe event,	o Be	17. Father's Name (First, Middle,	· ·							aiden Surnam	e)	
Maryland	uld be d Ment marke natic	욘	William K.  19a. Informant's Name/Relations		Till (in		(0)			E. Jo		State Zie	Cadal
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Catherine E. J			Mailing Address 7 Jasmi							
Baltimore,	t of He If item or othe		20a. Method of Disposition 1 □ Burial 2 【 Cremation	3 ☐ Removal from State	cemeten	Disposition (Nai crematory or c	other place	:e)	Date		20c. Location	-	
Itim	it. Pag irtmen irtant; iriniy		4 ☐ Donation 5 ☐ Other ( 21. Signature of Funeral Service	(Specify)	Ft. Li	ncoln C	rema	tory (	07/25/ .Simpl	2011	Brentw ute Fu	nera	Maryland 1 &Cremation
Ba	permit Depar Impor any in once.		21. Signature of Pulleral Service	~ molä	294	1040 R							
			23a. Part 1. Enter the disease, o shock, or heart failure. List	or complications that cause only one cause on each lir	d the death. Do no	t enter the mod	de of dyin	g, such as o	cardiac or res	piratory arres	it,		Approximate Interval Between
	Phy ician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. trìs	omy 1	8							Onset and Death
	Examiner			imv e	rasa consequence of): le lo menin a o cele								
,	- 4	iner	Sequentially list conditions, if a n, leading to immediate cause. Enter Underlying	b. Due to (1r as	a consequence d								
	executed an and rial-tribe	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequence o	):							
00	ath certificate be exe attending physician for use as the burial	_		d									
68760	ertificat ding ph	/Mec	IF FEMALE:	23c. If yes, outcome	of pregnancy						00.1.0	-16-1-	
Box (	eath or attend d for us	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 4 Pregnant	2 Fetal death at time of death	3  Ectopic 5 Other (s		СУ				ate of de onth	Day Year
P.O. E	it the d I by the stached	Phys	9 Unknown  Part II. Other significant condit	g Unknown		the underlying	cause ni	ven in Part I		220 Did tob	3000 USA COD	tribute to	the cause of death?
s, P.	requires that the de been signed by the should be detached	Completed by Physician/Medical	club foot	_		and discorying	occoo gi						robably 4 🗆 Unknown
Division of Vital Records,	iw requast beer 2 should	24a. Was an autopsy prior to completion of car									topsy findings available completion of cause of		
Rec	rsician; The law I s certificate has k lirector, page 2 s	Com								perforn 1  Yes 2	ned?	death?	s 2 🗆 No
/ital	sician certifi	To Be	25. Was case referred to medica examiner?  1  Yes 2  No	Hospital:	tient 2 🗆 ER/Out	nationt 2 🗆 🗆	Oth		th (Check onl		nce 6 🗆 Oth	oor (Spec	
of \	ng Phy ter this neral d		27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a. Date of inj	ury 28b. T		28c. Injur worl	y at			w injury occur		
sion	ttendir death. tor: Af the fu	Certificate:		tigation	jury - At home, far	М	1 🗆	Yes 2 🗆		1	and and Mund	hor or Pu	ral Route Number,
Divis	al or A s after Il Direction by	Se	4  Homicide deten		tc. (Specify)	II, Street, lactor	ry, onice		201.	City or Town		Jer or na	rai riodie ivanisci,
_	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur	Medical	(Check 2 Medical	ng Physician: To the best of Examiner: On the basis of	examination and/or	investigation, in	my opini	on, death oc	curred at the	time, date and	d place, and di	ue to the	cause(s) and manner stated
	To the	ž	only one) 3 Certifyin 29b. Signature and title of certifie	ng Nurse Practioner: To the er	e best of my knowle			e time, date e number	and place, ar		cause(s) and n 9d. Date signe		
	3		> ha	M	M.D.		4:	3225	5	<	July	15	2011
			30. Name and address of person Madhu Nigem	who completed cause of	M.D.  death (Item 23a) (I	ype, Print) Cente	r D	rive,	Boda	ille, M	ary lan	e:	20850
	Sta		31. Date filed (Month, Day, Year)  JUL 22	32. Regist	rar's Signature	bares							
	Registr	ar	JUL 22	cuit Kentur	ח ייק ע								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 25051 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24<sup>Day</sup> 2011 Physician/ Month Esther Louise Grim 11:49 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Reeder's Memorial Home Washington Boonsboro 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Months 1 □ M 2XX Hours Min. Sept. 24, 1928 <sup>C</sup>Maryland 212-24-7233 Director 82 Usual Residence of Decedent 28a-f shov 10a State 10b. County must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Washington Boonsboro 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 141 South Main Street 21713 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Force 1 Never Married 2 Married Black, White, etc. ģ 1 Ves WNo 1 ☐ Yes XX No Specify: 3**XX**Widowed 4 ☐ Divorced Specify: Completed Year or Dates White and 2 should e filed within 72 hours traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Name: Grim, Esther L Baltimore, Maryland 2121 College (1-4 or 5+) Elementary/Seconday (0-12) Bookkeeper Tire Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ Lloyd Russell Campbell Sarah Estelle Otzelberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Grim- Son 7920 Mapleville Rd. Boonsboro, Maryland per it. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specific Samples Manor Cemetery 7-28-2011 Sharpsburg, Maryland 21. Signature of Funeral Service L Osborned Auneradity Home, P.A. #25 S. Conococheague St.Williamsport, MD 21795 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ TIPLIVE MILURE disease or condition Month Medical resulting in death) Due to (or as a consequence of) **Examiner** ADVANCED DEMENTIA Yeme Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of 1) BYLL TY Yares burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗚 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsv performed? death? this certificate Yes 2 🔁 No Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 Yes 2 WNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Phospital or Attending Pl 24 hours after death. Funeral Director: After the Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 4658 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ghazala Qadir 20311 Lappans Road, Boonsboro, MD 21713 301-432-8470

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011

_			for State Registrar		State of	iviaryia		-	ificate of			-	Glene Reg. No.	7111		2505	52
	Physici		1. Decedent's Name (First, N	liddle, La	st)			60	rmar	\	2	2. Date of De Month	ath Day	Ž 20	r	3. Time of Dea 5:00 P	
-Cen	/Medic Examir		4a. Facility Name (If not instit	ution, giv	11 1	ber)	1-1		lb. City, Town,	1	on of Death	.1	4c.	County of De	66 1	J • 0 0 •	
-	Funeral		5. Social Security Number	10F	KINS t	105 / I 7. Age (In yi	rs. last birti		If Under 1 Year		der 24 Hrs. 8	B. Date of Bir (Month, Da	th Variable	9. E	Birthplac	e (State or Fo	reign
	Director		219-68-3429 Usual Residence of Deceden		₩ 2 □ F	46	١	rs.	Months Days	Hour		JULY 2			NNE (	CTICUT	
	ryland show	_	10a. State 10b. Co.				City, Town								10d.	Inside City Li	
	the Ma 28a-f s	Director	VA 10e. Street and Number			AI	JEXAN]	DRIA	10f. Zip Code				10a Citi	zen of What	Country	XXYes 2□	] No
	h with 23a or		801 S. PITT S	TREE	T #332				22314				U.S		Couriny	•	
21215-0036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show safeat Examiner rust be notified at	d by Funeral	11. Marital Status  1 ☐ Never Married 2X  3 ☐ Widowed 4 ☐ Divor		12. Was Deced Armed Ford 1 □ Yes 2 If Yes, Give Year or Da	ces? 2 <b>X</b> No e	U.S.		s Decedent of es, specify Cub			ify Yes or No can, etc.)		14. Race - Ar Black, WI Specify: W	nite, etc.		
15-(	i within 72 ho giene. ir than "natu ir e Medical	plete	15. Dece (Specify only hi	ghest gra	ide completed)		16a.	Deceder (Give kir life. DC	nt's Usual Occu nd of work done NOT use retire	pation during n d)	nost of working	,	16b. Ki	nd of Busines	ss/Indus	stry	
212	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-1	2)	College (1	4or 5+)		NER_						ESTAT	E C	OMPANY_	
Maryland	d be filled a ental Hygi ced other c event, III	Be	17. Father's Name (First, Mid		)						other's Name (		, Maiden	Surname)			
aryl	and Mark	ြင	MICHAEL GORMA  19a. Informant's Name/Relat		Type. Print)				Address (Stree	t and Nui		Route Numb	er, City o	r Town, State	e, Zip Ce	ode)	
	l and 2 Health Im 27 f		COLLEEN KELLY	HUG	HES (WII		LALI	<b>TXAN</b>	PITT S DRIA, V	TRGI	NIA 223	314	00-1-	0'1		21-1-	
nor	ages fent of H		20a. Method of Disposition  1 XBurial 2 ☐ Cremati  4 ☐ Donation 5 ☐ Othe			tate	cemeter)		on (Name of tory or other pla	ice)	Dat			cation - City			
Baltimore,	permit. Pages 1 and 2 should be filed Inpoparant: If item 27 is marked othe Important: If item 27 is marked othe any Injury or other traumatic event, once.		21. Signature of Funeral Serv	rice Licer	nsee		IL OI	22. 1	lame and Addr		cility DEMA]	NE FU	NERA	L HOME		ING, MD	
			23a. Part 1. Enter the disease	, or com	DWNEC	used the de	ath. Do n	-	OS. WA					XANDRI		/A 2231 pproximate iterval Betweel	
	Physician /Medical Examiner		shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	List only	a. STAGE	-			LCEU	LU	NGCA	NCE!	R		Ö	nset and Deat	h
	ited nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹		i as a const	equence of	ij.									
, 0	tificate be executed g physician and as the burial-transit		that initiated events resulting in death) Last		Due to (o	r as a conse	equence of	f):							+		
68760,	icate b physic s the bu	edical		•	d										-		
P.O. Box (	attendir for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1		rth 2□Fe ant at time o	etal death		ctopic pregnan Other <i>(specify)</i>	су			1	23d. Date of Month	delivery Da	ay Year	
ords, l	e law requires that the de has been signed by the e 2 should be detached	þ	Part II. Other significant con	ditions o	ontributing to dea	th but not re	esulting in	the unde	erlying cause gi	ven in Pa	ırt I.	23e. Did t		,		cause of death ly 4 □ Unkr	
Division of Vital Records,	ding Physictan: The law n. n. After this certificate has be funeral director, page 2 sh	Completed	25. Was case referred to med	ical						00 84		1 ☐ Yes	psy ormed? 2 ☑No	prior death	to comp	y findings avai letion of cause	able of
Ž	nysicia nis cert directe	lo Be	examiner?	icai	Hospital: 1 ☑ In	patient 2	☐ ER/Out	patient	3 □ DOA Oti	her.	ace of Death (			6	pecify)	·	
o uc	ding PI	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Per			Injury , Day, Year)	28b. Ti Inj	me of jury	28c. Inju Wo	rk?		d. Describe	how injur	y occurred			
Divisi	al or Attences after death	Certification: To	3 Suicide 6 Co	estigation uld not be ermined	28e. Place o	f Injury - At g, etc. <i>(Sp</i> e	home, farr cify)	n, street	, factory, office	]Yes 2		f. Location ( City or To	Street an wn, State	d Number or )	Rural F	Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (	29a. Certifier 1 ☑ Certi (Check only one) 1 ☑ Certi	fying Ph cal Exan	ysiclan: To the bankiner: On the bankiner	sis of exami	nowledge, nation and	death o	ccurred at the t stigation, in my	ime, date opinion,	e and place, ar death occurred	nd due to the d at the time,	cause(s date and	) and manne I place, and o	r as stat due to th	ed. le cause(s)	
	To the within Comp.	¥	29b. Signature and title of cer	tifier	111				29c. Licen				29d. Dat	te signed (Mo	onth, Da	y, Year)	
	00		January 30. Name and address of pers	110	Mod 2	of death /li-	em 23a\ /T	Vne Dri	RES	00	00		JUL	Y 22	1 , d	1011	
R	20		SGNJA		042					11	600 NO	rth Wo	Ife S	St Bal	time	re MDZ	1267
	Sta Registra		31. Date filed (Month, Day, Ye JUL 2 5 2011		32. Re	gistrar's Sign	ack	,						,			

DHMH 17 Rev 1/2001

Hospital

State Registrar (Check only

31. Date filed (Month.

29b. Signature and title of certifier

30 C Mos

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Reginrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 13  ${
m JULY}$ 2011 KEVIN HILL 6:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death FT. WASHINGTON HOSPITAL PRINCE GEORGE'S FORT WASHINGTON 5. Social Security Number 8. Date of Birth (Month, Day AUG • 27 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F Months Days Hours MARY LAND **Director** 215-92-5604 1964 46 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No PRINCE GEORGE'S ACCOKEEK 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1300 ACCOKEEK LANDING DRIVE 20607 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Examiner Black, White, etc. 1 Never Married 2 XMarried þ Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 XNo Specify: 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th CORRECTIONAL OFFICER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WILLIAM FREEMAN HILL JUANITA MONAJOY WRIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHERYL C. HILL/WIFE and 2 s Health 1300 ACCOKEEK LANDING DRIVE ACCOKEEK, MARYLAND 20607 or other item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State MD VETERANS CEMETERY 7/22/2011 4 Donation 5 Other (Specify) CHELTENHAM, MARYLAND J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 1asa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician ARREST disease or condition CARDIAC Medical resulting in death) Due to (or as a consequence of) **Examiner** CONGESTIVE HEART FAILURE Sequentially list conditions. Examine if a ry, leaung to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or): DIABETES MELLITUS that the death certificate be executed sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Tyes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2X 1 ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: မ 1 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA hours after death. Ineral Director; After this d filled in by the funeral di this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 \(\sum \) Yes Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural 2 Accident
3 Suicide 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifie

RUTH NO. 31. Date filed (Month, Day, Year)

RUTH ROBINSON M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

29c. License number H0055542

888 BESTGATE ROAD SUITE 111 ANNAPOLIS, MARYLAND 21401

JULY 20, 2011

11-05652 Rodrick Kibler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene 2011 25055

	1- For State Registrar Reg. No.										
Physician/	Decedent's Name (First, Middle,Last)		Date of Death     Month Day Year	3. Time of Death 2305 hrs							
Medical Examine	Rodrick Kibler  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	July 28, 2011 h 4c. County of Deal								
	Baltimore Washingtom Medical Center	Glen Burnie	Anne Arunde								
Funeral	Social Security Number	ay) If Under 1 Year If Under 24Hr		rthplace (State or							
Director	215-86-9706 1 M 2 F 45	Yrs. Months Days Hours Min	03/23/1966 Fore	ountry)Wash,DC							
ku e	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits							
and show	MD Anne Arundel Sever	n		1 Yes 2 X No							
th the Maryland 23s or 28s-f sho notified at orce.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co.	untry?							
th the notifical	1808 Clearwater Ct 11. Marital Status 12. Was Decedent Ever in U.S. 11	21144  3. Was Decedent of Hispanic Origin? ( S	USA	rican Indian, Black,							
r death with or items 23 cmust be no	1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puert	Rican, etc.) White, etc.	rical indian, black,							
fter de l'', or y Fu		1 Yes 2 No specify:	Specify:	White							
ours after authors after a samines and by		cedent's Usual Occupation (Give kind of ing most of working life, DO NOT use re		/Industry							
215-0036 be filed within 72 hours a tall Hygiene. ked other than "natural nit, the Medical Examination, the Completed by Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)  11  Dis	abled	N/A								
5-00; led with tygiene other ti	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	<del></del>							
21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica fo Be Comple	Rodrick Kibler, Sr.	Sandra	L. Vermillion								
U a Bra all	19a. Informant's Name/Relationship (Type, Print)  Sandra L. Kibler / Mother	Sandra L. Kibler / Mother 1808 Clearwater Ct.,									
re, MI 1 and 2 s Health a fitem 27	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of I crematory	Date 20c. Location - City o	r Town, State								
Pages nent of	4 Donation 5 Other Specify: Metro	5/2011 Baltimore	e, MD								
Baltimore, permit. Pages I at Department of Her Important: If ite Imjury or other tr	21. Signature of Poneral Service Licensee	22. Name and Address of Facility Bo		771 E							
	23a. Part I. Erper the disease, or complications that caused the death. Do not e	6512 NW Crain Hwy	,	715 Approximate Interval							
Physician  **	failure. List only one cause on each line.		Volume	Between Onset and Death							
xaminer	or condition resulting in death)  Due to (or as a consequence of):										
6	Sequentially list conditions, If any, leading to immediate  b. Dilated Cardiome  Disc to (or as a consequence of):	galy with Biventri	cular Hypertrophy	-							
ai e	cause. Enter Underlying Cause (Disease or injury that initiated c.										
recuted and transit	events resulting in death) Last  Due to (or as a consequence of):  d.										
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lox 68760, eath certificate be exe attending physician for use as the burial -/sician/Medic.	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	3	23d. Date of delive	•							
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P.O. es that the igned by be detach	Part II. Other significant conditions contributing to death but not resulting in Tunnel Coronary Artery	the underlying cause given in Part I.	23e. Did tobacco use contribute to								
ords, I w requires us been sig should be	Tunner obtonary Artery	_		utopsy findings available							
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed			performed? death?								
tal Recidan: The certificate rector, page	25. Was case referred to medical	26.Place of Death (Check	1 ✓ Yes 2 No 1 ✓ Y	es 2 No							
f Vital Physician or this certi ral director To Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outp	atient 3 DOA Other Nursi	ng Home 5 Residence 6 Othe	er:							
Jing Pl	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Tin	28d. Describe how injury occurred									
Sior Attend death death sctor: by the catic	Pending  Accident Investigation   28e. Place of Injury - At home, farm	28f. Location (Street and Number or R	ural Poute Number City								
Division o spital or Attending hours after death.  neral Director: After filled in by the fune Certification:	Suicide Could not be determined (Specify)	, street, ractory, onice building, etc.	or Town, State)	arar Rodio Hamber, only							
C Line hours	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death										
To the Howithin 24 h To the Funcompletely	one) 2 Medical Examiner: On the basis of examination and/or inventor and manner stated.										
> \ \sigma	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Mi	onin, Day, Year)							
	30. Name and address of person who completed cause of death (Item 23a)	0.0.00	1 34., 25, 2511								
Ow	Carol Allan, MD Assistant Medical Examiner 900 W.	Baltimore Street, Baltimore, M	ID 21223								
State		banks!		-							
Registra	Strate AUG 0 2 2011 Denous B. Jacks										

Baltimore, Maryland 21215-0036 Box 68760 P.O. Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 28 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Hours Country) Virginia Director 578-42-6165 79 Usual Residence of Decedent o Mental Hygiene. n arked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director 1X Yes 2 □ No Maryland 10e. Street and Numbe Bowie Prince George's 10f. Zip Code 10g. Citizen of What Country? Funeral 12319 Stonehaven Lane T18 20715 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: Specify: 3 Widowed 4 X Divorced Year or Dates. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) White House Secret Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Delmas C. Keller Virginia Dare Halsey and Men is n arke and 2 should to Health and Mer tem 27 is n ark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 926 Perry Landing Court Annapolis, MD 21401 Doris L. Overstreet/ Sister Department of Healtl Important: If item 2' any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/20/2011 Davidsonville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) nelimonic Medical Examiner ongestive Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or are a consequence of) death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Year 9 Unknown Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 N this certificate 2 🗆 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 E 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical 2001 State JUL 2 1 2011 Registrar

DHMH 17 Rev 7/2009

		,	State of Maryland / Department State		lental Hygie	ne 2011 25057
			1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg.	NoC U   2 J U J
- 2	Physici		Gladys Eldora Keegan			2011 Year 4:35 p. M
4	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
and	LAUIIIII	•	Moran Manor Nursing Home	Westernport		Allegany
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
Н	Director		233-66-7323 TIME 264 P 96 Yrs.		April 20,	,1915 Maysville, WV
	/land ow at		10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	Many a-f sh ified	tor	WV Mineral Keys	er		1 X Yes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ath w		500 Carskadon Lane, Apt. 316	26726		USA
	items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
336	ırs af al",or xa⊞i	by	If Yes, Give  3 ☑ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
o Q	72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ina 16b	. Kind of Business/Industry
2	ne. han ", e Mec	mple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	9	0 11
Maryland 21215-0036	iled w Hygie ther tl nt, th	S	8 H	Iomemaker	e (First, Middle, Maid	Own Home
and	d be i	To Be	Henry B. Hawk		L <b>e</b> ola Juni	,
ary	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notifiled at	Ě		ng Address (Street and Number or Rui		
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ore	Pages 1.		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State	matani as atherniana)		. Location - City or Town, State
altimore,	t. Pages tment of tant: If it		4 □ Donation 5 □ Other (Specify) Kalbaug	h Cemetery July 20	11   1	Elk Garden, WV
Ba	permit. Pages Department of Important: If it any Injury or of		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		ith Funera	
r			23a. Part1. Enter the disease, or complications that caused the death. Do not ent	85 S. Main Street ter the mode of dying, such as cardiac		Approximate
100	Physician		shock, or heart failure. List only one cause on each line.	art Failure		Onset and Death
9	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	wir runn a		2mmfy
	Examiner		Sequentially list conditions, b. Due to or as a conse uence of :			
	led sit	Examiner	Due to or as a conse uence of: Cause, Disease or injury			
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Вох	ath ce ttendi or use	Physician/Med	23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	⊒Ectopic pregnancy		23d. Date of delivery  Month Day Year
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0	Physical this caracteristics	2	1  Yes 2 No Hospital: 1  Inpatient 2  ER/Outpatien  27. Manner of Death 28a. Date of Injury 28b. Time o			e 6 Other (Specify)
o	ding h. After funer	tion	1 Matural 5 Pending (Month, Day Year)	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how i	injury occurred
Division or	Atten r deat ector	fica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined building, etc. (Specify)			et and Number or Rural Route Number,
	tal or s afte al Dir ed in	Certification:	4		City or Town, S	state)
	To the Hospital or Attending Physician: The law requires that the within 24 hours after feath.  To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier (Check only   Medical Examiner: On the basis of examination and/or in			
	thin 2 the l	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	ř ĭ ĭ S		Normal fli MD	00055325	- 250.	ulu 28 2011
	J Au		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		my 20, 2011
	0 0		WONGOCKSHIN MO 925 BIShop WU	Ish Rd Cumberlan	nd MD21:	502
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registr	ar	AUG 0 5 2011 Denur J. Barker			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25058 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Michael Vernon McNeal, Sr. 0<sup>Month</sup> 18<sup>2</sup> 20Î1 9:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 580 Sunshine Way Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign Age (In yrs. last birthday, Funeral **™** M 2 □ F Days Hours 03/18/1949 62 MD Director 217-46-4069 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location 72 hours after death with the Maryland Director 1 Yes 2 XNo MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 580 Sunshine Way 21157 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 1968—
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced 4 Divorced White 1970 Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Secretary of the permit. Page 1 and 2 should be filed within i Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Manan injury or other injury or other traumatic event. College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Senate Keeper of Stationery æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hazel Eleanor Burton Harry Vernon McNeal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Eberling McNeal/wife 580 Sunshine Way, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crestlawn Memorial Gd:07/23/2011 Marriottsville, MD 22. Name and Address of Facility Pritts Funeral Home & Chapel Signature of Funeral Service icensee 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph\_sician/ Cancel bla 13/10+07/12/11 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death. Due to (or as a consequence of): resulting in death) Last burial-1 physician the burial Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? 1 Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital 2 No 1 Tes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA this ( 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier WIL MI) 7-19-201 V0064597

12+1VA

Registrar

DHMH 17 Rev 7/2009

State

CROSSROADS Dr.

32. Registrar's Signature

Ste 340 Owings Mills, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-05449	ahaa Oahh	Please Type	or Print in Bl	ack indei	ible ink. E	th and Mant	opies Are L		1 25059
Dawn Valerie Murp	1- For State Certificate of Death								
Dimension	Registrar	nt's Name (First, Middle,	ast)	Certific	ale of Deal		2. Date of I	Reg. No. Death	3. Time of Death
Physician Medical Examine			MURPHY-	COBR			Month July 21	Day Year , 2011	0727 hrs
		y Name (if not institution, dy Grove Hospital	give street and number)		4b. City, Rock	Town, or Location of ville	f Death	4c. County of Dea	th
Funeral Director	5. Social s	Security Number 6	Sex 7. Agr	e (In yrs. last bir	thday) If Und Monti	der 1 Year If Under hs Days Hours	Min	Fore	
		sidence of Decedent		10. 01. 7					10d. Inside City Limits
and show any ace.	10a. State	10b. County  MONTA	DMERY	10c. City, Town		ANTOW	N		1 Yes 2 No
he Maryla or 28a-f ified at o	10e. Stree	et and Number	=DSONO.	LANE	10f. Zij	Code 20274		10g. Citizen of What Co	untry?
more, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  The Maryland water than "ostural", or items 23a or 28a-f shown other traumatic event, the Medical Laminer must be notified at once To Re Commisched by Finneral Director	11. Marita		12. Was Decedent Armed Forces? 1 Yes 2		13. Was Deced	ent of Hispanic Origi ify Cuban, Mexican,	in? ( Specify Yes or Puerto Rican, etc.)	No- 14. Race - Ame White, etc.	erican Indian, Black,
s after or inner n	3 🗌 WI	_	oed If Yes, Give Year or Dates:			No specify:	ind of work done	Specify: LC	AITE a/Industry
11215-0036 Id be filed within 72 hours fental Hygiene. arriced other than "asturevent, the Medical Language.		edent's Education (Specifi stary/Secondary (0-12)	College (1-4 or	5+)	during most of wo	I Occupation (Give k	use retired)	ol /s as l'a	
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygien a 27 is marked other than sumatic event, the Medica	17 Father	r's Name (First, Middle, L	ast)	[ []	one su	LICITER 18.Mother's	s Name (First, Midd	Ile, Maiden Surname)	CENTER
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21; od Mendd thould the marking markin		mant's Name/Relationship				•		Number, City or Town, Sta	1
MC 2 sightly and 2 sightly and 2 sightly are 27 reums	JAM 20a Meth	od of Disposition	USBAND	20b. Place	of Disposition (Na	me of cemetery.	LANE, GERI Date	20c. Location - City	or Town, State
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If them 27 is marked other it injury or other traumatic event, the Med	1 🗌 Bu	rial 2 Cremation		ate cremat	ory or other place	e)	7-3-11		
altin mit. Pa partmer portani		nation 5 Other Special Other Other Special Other Special Other Special Other Other Special Other Other Special Other O		WIRRO	22. Name and	d Address o Facility	DAUGHE	ATY FUNERA	
	AX	Kehm	MOO	942	2601 M	DUNTAIN AT	> PEADEN	1.MD. 21122	Approximate Interval
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iner	Sequentia if any, lea cause. E	ally list conditions, ding to immediate mer Underlying Cause	Due to (or as a conse	equence of):					
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68760, ertificate be ding physici e as the buri	IF FEMAL 23b. Was	decedent pregnant in the	23c. If yes, outcor		Fetal death	3 Ectopic	pregnancy	23d. Date of deliver	ery Day Year
. Box 68760, the death certificate be ex by the attending physician sched for use as the burial	past 1 Yes	2 months? s 2 No 9 ✔ Unkno		time of dooth	5 Other (Spe	ecify)		-	
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Records,  The law require: ficate has been sig., page 2 should be							1 <b>✓</b> Y	erformed? death'	
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Div To the Hospital of within 24 hours a To the Funeral D completely filled		fier 1 Certifying Phy	ner:On the basis of exam	y knowledge, de mination and/or	ath occurred at th	ne time, date and pla ny opinion, death occ	ce, and due to the	cause(s) and manner as si date and place, and due to	ated. the cause(s)
To the Ho within 24 To the Free completed	29b. Sign	ature and title of certifier	and manner stated.			c. License number		29d. Date signed (M	
		and				O.C.M.E.		July 22, 2011	
		and address of person w	no completed cause of c		V. Baltimore	Street, Baltimo	re, MD 21223	-	
Stat	21 2 1	iled (Month, Day,Year)	47	r's Signature	/				

			For State Registrar	State of	Marylan		artmen tificate			and M		giene Reg. No.			250	60
	Physicia	ın/	1. Decedent's Name (First, Middle, La								2. Date of Dea	Dav	Ye Ye	ar	3. Time of	
ي د مادر	Medic	cal	Ora Mae Mo								July 1		011		8:50	A M
	Examir	ier	4a. Facility Name (if not institution, giv St Thomas More N		,		4b. City,		Location o				County of E		ranta	
	Funeral		5. Social Security Number 6. 3	Sex 7.	Age (In yrs. Ia		If Under	1 Year	tsvi If Under	24 Hrs.	8. Date of Birt	th	9.	Birthpla	ce (State o	r Foreign
	Director		239-36-23/1	□ M 2 🖾 F	82	Yrs.	Months	Days	Hours	Min.	$c^{(Month,Day}$	<sup>v, Y</sup> 1392	8 N	orth	Caro	lina
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	with s 23a ust b	Funeral Director	5621 61st Place					2073	7			1	Unite	d St	ates	
	death items items		11. Marital Status	12. Was Deceder Armed Force		3. 13. V	Vas Deced f Yes, spec	ent of His	spanic Orig	gin? (Spec	ify Yes or No- ican, etc.)	-	14. Race - A Black, W	mericar	Indian,	
36	after I", or xamii	d by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2	X No		☐ Yes						,	Blac		
21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	Be Completed by	15. Decedent's l	Year or Dates Education	š.	16a. Deced	ient's Usua	l Occupa	ition			16b Ki	nd of Busine	ess Indu	strv	
215	n 72 ł e. ian "n Medi	dwo	(Specify only highest g	rade completed) College (1-4 o	or 5+)	(Give I	kind of wor O NOT use	k done di	uring most	t of working	g				,	
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nd	e filed ntal Hy ed otl	To B	17. Father's Name (First, Middle, Last)								(First, Middle,		,			
ž	uld b d Mer mark natic	-	Dan Willia  19a. Informant's Name/Relationship (			1					cy Dor					
Maryland	2 shoth and the and th		Idora M. McKelvi		nter	1	_				Route Numbe itland				<sup>de)</sup> 0746	
	f Hea item other		20a. Method of Disposition		20b. P	Place of Dispo	sition (Nam	ne of					cation - City		n, State	
E O	Page 1 nent of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		ate C	emetery, cren Harn	-	ther place	9	July 201	30,	Lan	dover	, Ma	rylar	ıd
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer	500 1	1			d Addres	s of Facilit		art Fu	nera	1 Hom	e, I	nc.	
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н			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	one cause on each	line.							rest,		1	Approximate nterval Bety Onset and D	ween
	Ph_sician/ Medical	1	Immediate Cause (Final disease or condition resulting in death)	Supan			a-Va	0	55+	LUC	Tion				The City	
and of	Examiner			Due to (or a	as a consequ	ience of):										
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	orted ord ansit	ami	Cause (Disease or linjury that initiated events	C												
	e exection are areas	dical Examiner	resulting in death) Last	Due to (or	as a consequ	uence of):										
90	ath certificate be executed attending physician and for use as the burial-transit	dic		d										+		
687	ertific ding p	M/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of pregna	ncy							23d. Date of	f dolivon	,	
Box	atten atten I for u	iciar	in the past 12 months?  1  Yes 2  No	1 Live Birl 4 Pregnar	th 2 🗌 Feta	l death 3	Ectopic p Other (sp		/			1	Month	-		/ear
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on	anding ath. ir. Afte	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	n	Day, Year)	injury	м	work?	Yes 2 🗌	No						
Division	il or Attendi after death. Director: A d in by the fu	ertil	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	28e. Place of	Injury - At ho etc. (Specify		eet, factory	, office		2	8f. Location (S		Number or	Rural R	oute Numb	er,
Ö	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director, After this certificate has been signed by the attending physician and funeral Director, After this certificate has been signed by the attending physician and ted filled in by the funeral director, page 2 should be detached for use as the burial-transit															
	To the Hospital or / within 24 hours after To the Funeral Dire completed filled in b	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical Examonly one) 3 Certifying Nu	iner: On the basis of	of examination	n and/or invest	igation, in r	ny opinior	n, death oc	ccurred at t	he time, date a	ind place,	and due to	the caus	e(s) and ma	nner stated
	To the within To the comple	Σ	only one) 3 L Certifying Nur 29b. Signature and title of certifier	ao Fractioner: 10 t	are near or tuly	, knowledge, c		License	_	ани ріасе	, and due to th		e signed (M			
	)		Vanlen	Work	m		J	Do	13.	52		JUL	L4 14	1 2	-011	
10	5		30. Name and address of person who	completed cause o	of death (Item	23a) (Type, P	rint)			,	Hycit			111	1-	
K			Paul A. DEVO	es mis	4203	Que.	ENGO	以及	1 74	عمر	Hycit	ナゴレ	i'lle	041.	120	3501
	Stat	te	31. Date filed (Month, Day Year)	32. Hegi:	stra s Signat	and I										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25061 State of Maryland / Department of Health and Mental Hygien [ ] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>011</u> Physician/ Donald William McGinn 8:20 Рм Ju<sub>1</sub>y Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens Nursing Home Silver Spring Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, 1 X M 2 D F Days Hours 081-20-7551 83 **Director** New York City, NY lugust Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🖾 No Prince George's Maryland Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3146 Gracefield Road, Apartment #422 20904 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give 10//-10 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1944-1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Greenbelt Homes Elementary/Seconday (0-12) College (1-4 or 5+) Comptroller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ William McGinn Lavenia Cleveland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. McGinn / Wife 3146 Gracefield Road, Apt. #422, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗵 Burial 2 🗌 Cremation 3 🗀 Removal from State cemetery, crematory or other place 7/25/2011 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Squamous Cell Carcinoma disease or condition resulting in death) Month Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 🔀 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pendina safter death 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date/signed (Month, Day, Year)

R 15+1

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

2 2011

 $J_{
m ul}$ aine Harding, 3110 Gracefield Road, Silver Spring, MD 20904

32. Registre 's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	_		For State Registrar	State of Maryland		tificate of E			2011	25062	
	Physicia		1. Decedent's Name (First, Middle, Last)  Alice Virginia	Marschat				2. Date of Death 0 7 1 8 - 2	Olay 1 Year	3. Time of Death 12:45 AM	
The state of the s	Medic Examin	er	4a. Facility Name (if not institution, give stand for doaks  5. Social Security Number 6. Sex	reet and number) Center	at biotherns	4b. City, Town, or Clinto	Location of Death  n  If Under 24 Hrs.		4c. County of Dea Prince (	m George's	
	Funeral Director			7. Age (In yrs. las	Yrs.	Months Days	Hours Min.	1 2 2 2 1 1 2 2 2 1 1 1 2 2 2 2 2 2 2 2	929	thplace (State or Foreign DC	
	ryland I-f show ied at	ctor	10a. State 10b. County		Town or Loc	ation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	the Ma or 28a e notif	Funeral Director	MD Prince G 10e. Street and Number	eorge's Cli	nton	10f. Zip Code		10	g. Citizen of What Co	A	
	s 23a nust b	neral	7520 Surratts R	oad		20735		U	SA		
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	Completed by Fur	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates.		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🕅 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Whi	e, etc.	
21215-0036	72 hour n "natu fedical	nplet	15. Decedent's Edu (Specify only highest grad		(Give k	ent's Usual Occupa aind of work done of NOT use retired)	ation during most of work	king	3b. Kind of Business	Industry	
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Maryland	be filed ental Hy rked oth ic even	To Be	17. Father's Name (First, Middle, Last)  Louis Anthony M	arschat				ne (First, Middle, Ma Sue Cur			
lary	should and M is mar		19a. Informant's Name/Relationship (Type	e, Print)		-	and Number or Rur	ral Route Number, C	ity or Town, State, Zi		
e, N	and 2 Health tem 27		Mary Strunk/nie			Greene	Pr., I		Virginia Oc. Location - City or		
Baltimore,	Page 1 nent of ant: If it ury or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State cer	metery, crem	e Pk. C	e) Crem 07-2	1	Riverda1		
Balt	permit. Departi Import any inji		21. Signature of Funeral Service Licensee	Reid	22. C e	Name and Addres	ss of Facility	l 11 PA A	ve.,Suit	20746 land, MD	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Dementia									,	Approximate Interval Between Onset and Death	
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	cate be executed physician and the burial-transit	edical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):						
092	ite be e hysiciar he buria	dical	C d								
Box 687	ath certific attending for use as	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{NNo} \) 9 \( \text{Unknown} \) Unknown	Sc. If yes, outcome of pregnand  1  Live Birth 2  Fetal of  4  Pregnant at time of der  9  Unknown	death 3 🗌	Ectopic pregnand Other (specify)	у		23d. Date of de Month	slivery Day Year	
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ital	lysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2  No	ospital:		Othe	ace of Death (Chec	k only one)			
of V	ng Phys ter this neral di	te: To	27. Manner of Death	1 Inpatient 2 El 28a. Date of injury (Month, Day, Year)	R/Outpatient 8b. Time of injury	28c. Injury work	4 LA Nursing H	ome 5 Residence 28d. Describe how	ce 6 Other (Specinjury occurred	cify)	
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	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director After this of completed filled in by the funeral director.	Medical	(Check 2 Medical Examine	ian: To the best of my knowled r: On the basis of examination a Practioner: To the best of my k	and/or investi	gation, in my opinio	on, death occurred a	at the time, date and I	place, and due to the	cause(s) and manner stated.	
	To the within To the comp	2	29b. Signature and title of certifier		riowieuge, u	29c. License	number	290	d. Date signed (Mont	h, Day, Year)	
			30. Name and address of person who cor	Carrer of death (Itam 2	23a) (Tuno D	D352	00	] ]	uly 21,	2011	
12	_ 3		William T. Tan	ner, MD 1170	)1 Li		n Rd.,S	te.101,	Ft. Wash		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signator	alexand .						

			For State Registrar	State of Maryland		artment of tificate of		nd Me	ental Hygi	ene eg. <b>N</b> 20		25063
			Decedent's Name (First, Middle, Last)						2. Date of Death	1		3. Time of Death
	Physicia Medic		Evelyn L	. Madison				J	ully 8,	8, 2011 Year		7:27 A <sub>M</sub>
	Examin	-	4a. Facility Name (if not institution, give str	reet and number)		4b. City, Town,	or Location of	Death		4c. County of Death		
and "			Springtime				attsvil			P		e George's
Ī	Funeral Director		5. Social Security Number 6. Sex 1 $\square$	M 2 F 7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Yea Months Days			B. Date of Birth 1ay 8,	9. Birthplace (State or Foreign Country) DC		
	d t ow	ا ا	Usual Residence of Decedent	10e City	Town or Lor	ation						0d. Inside City Limits
	nylan i-fsh ieda	당	10a. State 10b. County 10c. City, Town or Location  DC Washington  10g. Citizen of 10g. Citize								Ι'	1   Yes 2 □ No
	r 28a notif	Dir.									. Citizen of What Country?	
	vith th	ral	704 Ingraham St	20011			ed St					
	ems ems	Funeral		2. Was Decedent Ever in U.S.	. 13. V	Vas Decedent of Yes, specify Cu		in? (Speci	fy Yes or No-	14. Rac	e - Americ	an Indian,
ဖွ	or it	by F	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No		Yes, specify Cu		Puerto Ri	can, etc.)		ck, White,	
8	urs af ural" al Exa	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		onter a necesio				Specify	Afri Amer	ican
5-	72 ho "nat edica	ple	15. Decedent's Edu (Specify only highest grade		(Give I	lent's Usual Occi	during most of	of working	,	16b. Kind of B		
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inpartment of Health and Mental Hygiene. Inpartment of Health and Mental Hygiene. and inpartment if the Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	욘	James All	en Madison				Car	rie Ger	rtrude	Hill:	ary
lary	should and N is ma		19a. Informant's Name/Relationship (Type	a, Print)		ig Address (Stree						
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ore	ye 1 a t of H if ite or oth		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ R		emetery, cren	sition (Name of natory or other pi	ace) J	July 20	19.	20c. Location	-	
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o Li	nding tth. ; After e fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	w	ork? ☐ Yes 2 ☐ I	- 1	od. Bosombo no	w mjary occan	.00	
Division of Vital Records,	I or Attending Physician: after death. Director: After this certific I in by the funeral director,	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	eet, factory, offic	е	21	Bf. Location (Str City or Town		oer or Rura	I Route Number,
<u>Ö</u>	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, that this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.											
	Hosp 24 hor Fune eted fi	Medical	(Check 2 Medical Examine	cian: To the best of my knowled er: On the basis of examination Practioner: To the best of my	and/or invest	tigation, in my opi	nion, death occ	curred at the	he time, date and	d place, and du	ue to the ca	use(s) and manner stated.
	To the within To the Somple	Σ	only one) 3 L. Certifying Nurse 29b. Signature and title of certifier	Tractioner, to the best of my	miowiedye, (		ise number	ана ріасе,		9d. Date signe		
			16	/		D5	3182			July 1	5, 20	)11
-	11		30. Name and address of person who con			rint)		-		1 00	770	
R	1		Cecil D. George,	M.D. 7500 Han	over I	arkway	Greent	pe⊥t,	Maryla	ina 20	770	
	Stat Registra	te ar	31. Date filed (Month, Day Year)  JUL 2 1 2011	32. Registrate Signat	ares							

		-	1 - State of Maryland / De State of Maryland / Co	partment of F ertificate of D	Health and N Death	∕lental Hygi Re	ene 201	1 25064	
			1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death	
	Physicia Medic		William Dwight McCool,	Sr.		July	27 201	1 0650 A M	
	Examin		4a. Facility Name (if not institution, give street and number)		r Location of Death		4c. County of		
			1233 Singerly Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	E1ktor	n If Under 24 Hrs.	8. Date of Birth	Ceci	Birthplace (State or Foreign	
	Funeral Director		215-32-2637 1 ▼ M 2 □ F 75 Yrs.	Months Days	Hours Min.	DEC 30,	Year) 1935	Pennsylvania	
	w		Usual Residence of Decedent					1011 11 07 11 17	
	ryland -f sho ied at	Director	10a. State 10b. County 10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 🏹 No	
	ne Ma	Dire	Maryland Cecil Elkto	n 10f. Zip Code		1	Og. Citizen of Wha		
	with the 23a cast be		1233 Singerly Road	2192	1		3	nited States	
	eath v	Funeral		3. Was Decedent of Hi	lispanic Origin? (Spe	ecify Yes or No-		American Indian,	
30	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 Yes 2 M No	1 ☐ Yes 2 🎇 No		Thoun, oto.,	Specify:	White, etc.	
3	ours a	Completed	3 Widowed 4 Divorced Pear or Dates.  15. Decedent's Education 16a. Dec	cedent's Usual Occup	pation		16b. Kind of Busir	White	
512	n 72 h  an "n Medi	ldm	(Specify only highest grade completed) (Gir	ve kind of work done of DO NOT use retired)	during most of work			nce and	
7	withii /giene ner th t, the		2	)wner			Real E	state	
Maryland 21215-0036	e filed ntal Hy ed oth even	To Be	17. Father's Name (First, Middle, Last)		18. Mother's Nam				
$\frac{3}{2}$	d Mer d Mer mark matic	-	John Morris McCool  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	ailing Address (Street a		Mendenh		e Zin Code)	
Z Z	2 shouth and 12 shouth and 15			33 Singerly					
Baltimore,	1 and of Hea item		20a. Method of Disposition 20b. Place of Dis	sposition (Name of rematory or other place			20c. Location - Ci		
Ē	Page 1 nent of ant: If it ury or o		I Duliai 2 La Cierration 3 Li heritovalillotti State I	ris & Co., I	nc. 201		West (	Chester, PA	
Salt	permit. Page 1.a Department of H Important: If it any injury or of		21. Signature of Funeral Service Licensee					erals, P.A.	
_	<u> </u>		Voned & Hicker		Stockton				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	nter trie mode or dyin	ig, such as cardiac	or respiratory arres	51,	Approximate Interval Between Onset and Death	
~	Physician Medical	G P	disease or condition resulting in death)  Due to (or as a consequence of):						
	Examiner								
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):						
	cuted	xam	Cause (Disease or injury that initiated events c.						
_	certificate be executed anding physician and use as the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):						
9	icate t g phys	l e	d						
80	v requires that the death certifica been signed by the attending p should be detached for use as t	Physician/M	IF FEMALE: 23c. If yes, outcome of pregnancy   1	Retonic preopane	cv		23d. Date		
ROX	death he atte	sici		Other (specify)			Month	n Day Year	
л. О	that the ned by tl e detach	, Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause gi	ven in Part I.	23e. Did tob	acco use contribu	ute to the cause of death?	
	ires th signe Id be o	d by				-11 Ye	es 2 🗆 No 3	☐ Probably 4 ☐ Unknown	
Vital Hecords,	law requires nas been sig e 2 should be	Completed				24a. Was ar		ere autopsy findings available or to completion of cause of	
Sec.	The lay	lmo;				autops perform 1  Yes 2	ned? dea	ath?  Yes 2 No	
e e	sian: T ertifice ctor, p	Be C	25. Was case referred to medical examiner?	26. Pl	lace of Death (Chec				
Ξ	Physic this ce al dire	은	1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa  27. Manner of Death   28a. Date of injury   28b. Time	-	4 ☐ Nursing H	ome 5 Reside		(Specify)	
n O	ding F h. After funer	sate	1 Natural 5 ☐ Pending (Month, Day, Year) injur	y work	yat k? ]Yes 2 □ No	28d. Describe ho	w injury occurred		
<u>S</u>	Atten r deat ector: by the	Certificate:	2		. 100 2 2 110			or Rural Route Number,	
Division of	tal or rs afte at Dire		building, etc. (Specify)			City or Town	, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s	Medical	29a. Certifier Certifying Physician: To the best of my knowledge, dea (Check 2 Medical Examiner: On the basis of examination and/or in	estigation, in my opinio	on, death occurred a	t the time, date and	d place, and due to	o the cause(s) and manner stated.	
	ithin 2	Me	only one) 3	e, death occurred at th			cause(s) and manr 9d. Date signed (/		
	/		Mucual MA	55	6979		7-2-	7-11	
	1/2		30 Name and appress of person who completed cause of death (Item 23a) (Type	e, Print)	0 0		115	21221	
	, Eu		14. Charbon 61+ steming	UR5	run b	D 15	ayo	2/201	
	stat Registra		AUG 05 2011 Section 32. Registrar's State of Control of						

		1	Amended I	tem 30	se Type o per Phy State	r <b>Pri</b> j	tin Alaryland	lack Ir Carr / Depa	ndelik artme	ole Ink Co., nt of I-	<b>k. Ens</b> wjl lealth	and M	<mark>II Copie</mark> Iental Hy	s Are	e Leg	ible.	
		•	For State Registrar							te of E				Reg. N	<u> 20</u>		25065
	Physicia Medic		1. Decedent's Nam Anna M	e (First, Middle Narie C							2. Date of Death Month Day Year July 17, 2011 7:00 p. M				3. Time of Death 7:00 p. M.		
-	Examir		4a. Facility Name (ii	not institution	, give street and r	umber)					Location		July		c. County		n
	·		Dove Hou			17 4		to the total of		Vestn er 1 Year	inste		0 Data = ( D)	- L	Car	roll	
	Funeral Director		5. Social Security N 220-22-3 Usual Residence of	3130	6. Sex 1		e (In yrs. last 84	Yrs.	Months		Hours	Min.	8. Date of Bi (Month, D	ay, Year)	927	9. Birti Cou MD	hplace (State or Foreign untry)
	nd show at	'n	10a. State	10b. County			10c. City, 7	Town or Lo	cation								10d. Inside City Limits
	Aaryla 8a-f s tified	Director	MD	Car	roll		I	Hamps	tead								1 🗌 Yes 2 🔀 No
	a or 2	Ö	10e. Street and Nur						10f. Z	p Code				10g. C	itizen of \	What Co	untry?
	h with	Funeral	3408 Sch	aefer						074				US			
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	<ul><li>11. Marital Status</li><li>1 Never Mari</li><li>3 Widowed</li></ul>		ried 1 7	Forces? es 2 X Give		<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puerto Rican, et al.</li></ol>					cify Yes or No Rican, etc.)	•	Blac	e - Amer ck, White : <b>wh</b>	
5-0	2 hour "natu	plet	(Spe		nt's Education est grade complet	ed)		16a. Deced			ation during mos	st of worki	ng	16b. l	Kind of B	usiness l	Industry
21215-0036	rithin 73 iene. r than the Me	Completed	Elementary/Sec	onday (0-12)	College	(1-4 or 5	+)		O NOT us	e retired)	Ü			OW	n ho	me	
	should be filed within 7 n and Mental Hygiene. f is marked other than raumatic event, the M	To Be	17. Father's Name	First, Middle, LCK GeC	rge Gile	s			<del>-</del> -		18. Moth Bark	ner's Name Oara	Fritch	e, Maiden	Surnam	e)	
, Maryland	and 2 should Health and N tem 27 is ma ther trauma		19a. Informant's N Norman (		hip (Type, Print) , Sr., H	usba							l Route Numb Iampste				
Baltimore,	permit. Page 1 ar Department of H Important: If iter any injury or oth		20a. Method of Dis 1 🔀 Burial 2 4 🗌 Donation	☐ Cremation	3 ☐ Removal fr Specify)	om State	cen	ce of Disponence	natory or	other plac			Date 0/2011		ocation time		Town, State
Balt	Depart Import any inj		21, Signature of Fu	neral Service	Licenses P	M007	41	,			ss of Facili	Lit	ine Fu				
	402 40		23a. Part 1. Enter	the disease of	complications th	MAN at caused	the death						Hamp		id, M	ID 21	Approximate
E.			shock, or hea	ırt failure. List	only one cause on	each line					<i>g</i> ,		, , , , , , , , , , , , , , , , , , , ,	,			Interval Between Onset and Death
	Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):														
	Examiner		Congestor hear failure														
	n #	ine															
	executed an and rial-transit	Examiner	Cause (Disease or that initiated event resulting in death)	ts	c. — Due	to (or as a	a consequer	nce of):					<del></del> -			-	
09	an an	1-1	resulting in death	Lust	d												
Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physicis tend filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ No 9 ☐ Unknown			ve Birth	of pregnance 2  Fetal continues of dea	death 3	Ectopic Other		су			23d. Date of delivery Month Day Year			
P.O.	requires that the de been signed by the should be detached		Part II. Other signi		ons contributing t	o death b	ut not result	ting in the u	underlying	cause giv	ven in Part	t 1.	23e. Did	tobacco	use cont	tribute to	the cause of death?
S, F	ires the signer of the signer	d by											1 🗆	Yes 2	2 🗆 No	3 🗆 Pi	robably 4 Unknown
Records,	w requ	Completed											24a. Wa				topsy findings available completion of cause of
3ec	The law cate has by page 2 s	E S											per	opsy formed? 2 <b>X</b>		death?	s 2 No
a	sician: The certificate h	Be C	25. Was case referrexaminer?	red to medical						26. PI	ace of Dea	ath (Check	k only one)				
of Vital	Physician: 'this certificaral director, I	은	1 🗆 Yes 2	<b>₩</b> No			ent 2 Ef				4 L N		me 5 🗆 Res				Mospie Facility
n of	ding Ph th. After thi funeral	ate	27. Manner of Deat	5 🗌 Pendi	ng (N	ite of injuitionth, Day		8b. Time of injury		28c. Injury work	₹?	- 1	28d. Describe	how inju	iry occuri	red	
Division	of or Attendent after deat Director:	Certificate:	2  Accident 3  Suicide 4  Homicide	6 Could deterr	28e. Pla	ace of Injuil	ıry - At hom :. (Specify)	e, farm, str		M 1 Yes 2 No et, factory, office 28f. Location (Street a City or Town, State						er or Rui	ral Route Number,
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completed filled in by the fun	Medical	(Check	2 Medical	g Physician: To the Examiner: On the g Nurse Praction	basis of ex	xamination a	and/or inves	stigation, in	n my opinio	on, death o	occurred at	the time, date	and plac	e, and du	e to the	cause(s) and manner stated.
	To t To t		29b. Signature and	title of certifie	(-				29	c. License						d (Month	h, Day, Year)
	Mar		• (	con		70					5050				18 hi		
			30. Name and add	ress of person	who completed c	ause of d	eath (Item 2	14.	273 No. 1	2111		ver I	Pike, E	lamps	stead	i, M	D 21074
	Sta	te	31. Date filed (Mon		32	. Pegistra	ar's Signatur					4-1-5	Ş 177D				
	Registr			1111 9	2011	12		1 1	an No	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patricia Carol Prouty 13 July 2011 11:50 A M Medical 4a. Facility Name (if not institution, give street and number)
309 Dawnwood Drive **Examiner** 4b. City, Town, or Location of Death 4c. County of Deatl Edgewater Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** Birun Country) **Iowa** 482-52-7965 1 M 2 XF 64 Months Days Hours Director Sept. Usual Residence of Decedent 28a-f shov must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Edgewater 1 Yes 2 X No ō 10e. Street and Number 309 Dawnwood Drive 10f. Zip Code 10g. Citizen of What Country? Funeral 21037 items 23a U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: White Completed Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Philanthropist Charity Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dwight William Paulsen မ Agnes Elizabeth Jensen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Prouty/husband 309 Dawnwood Drive Edgewater, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XX remation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Crematory 7/22/2011 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PAN CREATIC CANCER Physician METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence or Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month 1 Yes 2 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 6 Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) s after death.

I Director: After this d in by the funeral d Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifie within 24 ho To the Fune only one) Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) MO 19/2011 D0064852

State Registrar

DHMH 17 Rev 7/2009

2003 MEDICAL PARYWAY, SUITE 201. ANNAPOLIS, MO 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

OR RAVIN G
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25067 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JMH Physician/ 09 P M 20 Lois J. Pollard Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Doctors Community Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗶 F Months Davs Hours Min (Month, Day, Year 81 Director 578-44-9432 07/15/1930 Wash D.C Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City. Town or Location Examiner must be notified at Director 1. Yes 2 No Md. P.G. Upper Marlboro 10g. Citizen of What Country? 10e. Street and Numbe ò 10f. Zip Code Funeral [ 23a 10807 Trafton Drive 20774 U.S.A. items ? death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ₩ No Specify Black "natural" Completed 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry th and Mental Hygiene.
77 is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Information Analyst/N.S.A. U.S. Government 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edgar Johnson Henrietta Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, 5013 Ashborne Rd., Glen Allen, Virginia Joseph H. Pollard, Jr./Son 23060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/21/11 Beltsville, Maryland Chesapeake Crematory, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.F., Washington, D.C. 20019 23a. Part 1. Enter the distribute, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failule. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) r as a consequence of Examiner evitonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last ding physician se as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by P. Indlation 2 Probably 4 ☐ Unknown obs ruction 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 : autopsy performed? death? 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, examiner? Hospital: Other: ္ရ 1 Yes 2 No 1. Kinpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 5 Pending injury 1 Natural Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 ture and title of cer D0042049 Cleundal

State Registrar

DHMH 17 Rev 7/2009

Mb

Upper Manlboro

MO

Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHAMPALOUX

G .

31. Date filed (Month,

			For State State Registrar	te of Maryland		irtment of F tificate of L			giene Reg. No 2011	25068
	Physicia		1. Decedent's Name (First, Middle, Last) Herbert Harry			Philli	os, Jr	2. Date of Dea Month	20 <sup>Pay</sup> 2011	3. Time of Death 8:00 A M
-	Medic Examin		4a. Facility Name (if not institution, give street and 15720 Nelson Perrie R		/	4b. City, Town, or Brandyw			4c. County of Deat	
	Funeral Director		5. Social Security Number 230–60–5510 6. Sex 1 XXM 2 [	7. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	if Under 24 H Hours Mi		9. Bir (, Year) 945 Vir	thplace (State or Foreign untry) 31Nia
b.		tor	Usual Residence of Decedent  10a. State 10b. County	1	, Town or Loc					10d. Inside City Limits
	the Mary a or 28a-f be notifie	Funeral Director	Maryland   Prince George		ndywin	10f. Zip Code	1.0		10g. Citizen of What Co	1 ☐ Yes 2 🗷 No
	death with items 23 ier must I	Funera	15720 Nelson Perrie  11. Marital Status 12. Was Arm	Rd.  Decedent Ever in U.Sed Forces?	. 13. V	Vas Decedent of H	ispanic Origin?	(Specify Yes or No- erto Rican, etc.)	USA  14. Race - Ame Black, Whit	
9000	urs after o tural", or al Examir	ted by	3 ☐ Widowed 4 🗓 Divorced If Year	ed Forces? Yes 2 K No s, Give or Dates.	1	☐ Yes 2 No	Specify:		Specify: W	nite
21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade comp. Elementary/Seconday (0-12) Colle	leted) ege (1-4 or 5+)	(Give I	ent's Usual Occup kind of work done O NOT use retired) nist	ation during most of w	vorking	16b. Kind of Business  Manufactur	
and 2	should be filed within 7; and Mental Hygiene. is marked other than aumatic event, the Me	To Be (	17. Father's Name (First, Middle, Last)  Herbert Harry Ph	illips , S			18. Mother's N	Name (First, Middle,	Maiden Surname) ne Bibb	
Maryland	2 should th and Me 27 is mar traumati		19a. Informant's Name/Relationship (Type, Print) Lesley P. Rorick - Dau		19b. Mailir		and Number or	Rural Route Numbe	r, City or Town, State, Zi	
Baltimore,	permit. Page 1 and 2 s Department of Health i Important: If item 27 i any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal	20b. Pi	lace of Dispo emetery, cren	sition (Name of natory or other place <b>matory</b>	20)	Date	20c. Location - City or Edgewater,	Town, State
Baltir	permit. Page Department Important: I any injury o		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Logisee	Kai					Kalas Fune Hill, Mary	
	Di		23a. Part J. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final	that caused the death on each line.		1		iac or respiratory an	rest,	Approximate Interval Between Onset and Death
	Physician/ Medical Examiner		disease or condition	ue to (or as a consequ		ance				
	ted nsit	ıminer	cause. Enter Underlying Cause (Disease or iinjury	ue to (or as a consequ	ence of):	•		_		
0	be executed sician and burial-transit	dical Examiner	that initiated events resulting in death) Last	ue to (or as a consequ	ence of):					
68760	eath certificate attending phys	n/Medi		s, outcome of pregnar		] <b>5</b> .41			23d. Date of de	elivery
Box	he death y the atte	hysicia	1 Ves 2 No	Live Birth 2 Feta Pregnant at time of d Unknown		Other (specify)	cy		Month	Day Year
ls, P.O.	uires that the des n signed by the a lld be detached f	Completed by Physician/Me	Part II. Other significant conditions contributin	g to death but not rest	ulting in the u	nderlying cause gi	ven in Part I.	1	obacco use contribute t Yes 2 🗆 No 3 🌠 i	o the cause of death? Probably 4 🗆 Unknown
Division of Vital Records,	rsician: The law require: s certificate has been sid lirector, page 2 should b	omplet						24a. Was auto perfo	prior to death?	utopsy findings available completion of cause of
E	an: Th tificat tor, pe	Be C	25. Was case referred to medical			26. P	lace of Death (C		ZA ANO I TO TE	5 2 110
Vit.	lysicia is cer direct	10 B	examiner?  1 Yes 2 X No Hospital:	1  Inpatient 2	ER/Outpatier	nt 3 🗆 DOA Oth	ier: 4 🗌 Nursin	g Home 5 Resi	dence 6 Other (Spe	cify)
on of	nding Ph ath. r: After th	Certificate:	1 XXNatural 5 ☐ Pending 2 ☐ AccidentInvestigation	Date of injury (Month, Day, Year)	28b. Time of injury	wor	ry at k? ]Yes 2 □ No		now injury occurred	
Divisi	ral or Atters after de al Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e.	Place of Injury - At ho building, etc. (Specify,	me, farm, str )	eet, factory, office		28f. Location ( City or Tox	Street and Number or Ri vn, State)	ural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 X Sertifying Physician: To (Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Praction	he basis of examination	and/or inves	tigation, in my opin death occurred at ti	on, death occurr ne time, date and	red at the time, date a	and place, and due to the e cause(s) and manner a	cause(s) and manner stated. s stated.
	North Con		29b. Signature and title of certifier	6		29c. Licens	oloZ	>	29d. Date signed (Mon	
Y	13		30. Name and address of propin who completed Ivan Z		9200 Ba		rt #200	) Largo, l	Maryland 2	0774
H	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture					

DHMH 17 Rev 7/2009

i-05511 nthony W. Pope	е	State of Maryland / Departn	nent of Health and Mental H	ygiene	2011	25069
		I- For State Certific	cate of Death	Reg.		23003
Physicia ledical Exami	ın/	1. Decedent's Name (First, Middle, Last) Anthony W. Pope William Anthon	y Pope	2. Date of Death Month D July 23, 201	ay Year 1	3. Time of Death 1949 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death Prince George	
Funeral	4	Prince Georges Hospital Center  5. Social Security Number   6. Sex   7. Age (In yrs. last b	irthday) If Under 1 Year   If Under 24Hrs	B. Date of Birth (	MM/DD/YYYY) 9. Birt	
Funeral Director		579-82-7087 1x M 2□F 47	Yrs. Months Days Hours Min		3,1963 Foreig	<sup>n</sup> <sup>untry)</sup> Wash,D(
<b>b</b>	ļ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	on or Location			10d. Inside City Limits
d now any						1 Yes 2 No
Aaryland 28a-f show 1 at once.	Director	D . C .  10e. Street and Number	Washington 10f. Zip Code	10g.	. Citizen of What Cour	ntry?
3 or 3		2924 Mills Avenue, N.E.	20018			l States
ath with	Funeral	11. Marital Status  1 X Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
her de:		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:		Specify:	31ack
ours at	ed by		a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		6b. Kind of Business/I	ndustry
136 hin 72 h e. than "r	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	Laborer		Priva	a t o
21215-0036 and be filed within 7 Mental Hygiene. marked other than it event, the Medica	Completed	12th 17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
1218 il be fill ental H erked	Be	Willie Pope	9b. Mailing Address (Street and Number or	thell H	ill	Zin Codo)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ဥ		2924 Mills Ave.,N			) 018
Ce, No. 1 and 2 Health item 2	ı	20a. Method of Disposition 20b. Place	e of Disposition (Name of cemetery, latory or other place)	Date 2	20c. Location - City or	
MOT Pages nent of not: H		1 X Bunal 2 Cremation 3 Removal from State		-29-11	Brentwo	ood, Md.
Baltimore, permit. Pages 1 a Department of He important: If ite		21 Signature of Funeral Service/Licensee	22. Name and Address of Facility C 1425 Maryland	apitol	Mortuary	
Physician		26a, Part I. Enter the disease, or complications tylat caused the death. Do	not enter the mode of dying, such as cardiac	AVE. N or respiratory arres	E Wash. t, shock, or heart	DC 2000 Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Complications of	chronic alcohol abuse	and chron	ic narcotism	Between Onset and Death
<b>Examiner</b>		or condition resulting in death)  Due to (or as a consequence of):				
	Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (c. Due to (or as a consequence of):				
executed an and al - transit		d.	020 10 2 11 -			
	edical	XX FinerME G92	per me,g920 10-3-11 s 2,12/8/2011,WS	m 	23d. Date of deliver	,
3876 rtificate ing phy as the	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnant 1 Live birth	cy 2 Fetal death 3 Ectopic pregn	ancy		Day Year
Box 68760, e death certificate be the attending physicied for use as the buri	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)			
O. Bat the datached		Part ii. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.		acco use contribute to	
S, P.C.	ed by			1 Yes		topsy findings available
ords aw requas been	Completed			autopsy perform	prior to	completion of cause of
tal Reco	Con		26.Place of Death (Check	1 ✓ Yes 2	No 1 🗸 Ye	es 2 No
Vital Rec ysician: The I his certificate I director, page	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER	IOthor .		esidence 6 Othe	r:
ing Phy After th	$\vdash$	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28	b. Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
Sion Attend r death. ector: by the I	catic	2 Accident Investigation	1 Yes 2 No , farm, street, factory, office building, etc.	28f Location (Str	eet and Number or Ru	ıral Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)	, ighth, street, ideasy, enter building, etc.	or Town, Sta		100/1 1
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buni		29a. Certifier 1 Certifying Physician: To the best of my knowledge, one)  2 Medical Examiner: On the basis of examination and/o	death occurred at the time, date and place, an or investigation, in my opinion, death occurred	d due to the cause( at the time, date ar	(s) and manner as stated	ed. ne cause(s)
To t with To com	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	
4		Paratt (withall, not)	O.C.M.E.		July 24, 2011	
99		30. Name and address of person who completed cause of death (Item 23:	a) ner 900 W. Baltimore Street, Balt	imore MD 211	223	
	ate	31 Date filed (Month Day Year) 32 Registrar's Signature				
Regis		111 2 9 2011 June B. Sar	Kad			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ ] Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rhoten Elmer Ray July 2011 6:15a Medical 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Hospice If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 5/25/1932 1 🕱 M 2 🗆 F Months Hours Min 79 Director 214-34-4821 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he martical any injury. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 Yes 2 No Baltimore Parkton 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number Completed by Funeral 21120 USA 17608 Pretty Boy Dam Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) caretaker of horse farm horse farm Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ဂ Elizabeth Turnbaugh Elmer Rhoten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17608 Pretty Boy Dam Rd., Parkton, MD Patsy Rhoten, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Mt. Carmel Cemet. 7/19/2011 Parkton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M00741 S. Main St., Hampstead, MD 21074 934 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ concurre Medical resulting in death) Due to (or as a consequence of) **Examiner** myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to or as a consequence of): Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If <u>ye</u>s, outcome of <u>pr</u>egnancy 23d. Date of delivery 23b, Was decedent pregnant Live Birth 2 Fetal death 3 Fctopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death?
1 Yes 2 No certificate ! 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death

1 Natural
2 Accident
3 Suicide 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 29d. Date signed (Month, Day, Year) 29b. Signature and titl 201 MJL

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

4

houses ST pouson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25071 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -3. Time of Death Month 07/09/2011 1 ear 19:01 P M Physician/ William R.S. Rainford, Sr. Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death
Prince Georges 4b. City, Town, or Location of Death **Examiner** Cheverly Prince Georges Hospital If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F 104-64-9029 43 Director 05/24/1968 NY Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Prince Georges Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a Funeral AZU 20774 305 Etna Dr. or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married ð 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meagnee. Elementary/Seconday (0-12) College (1-4 or 5+) Computer-Consulting Network Engineer Be 18. Mother's Name (First, Middle, Maiden Surname)
Evelyn Trapp 17. Father's Name (First, Middle, Last) ည William Rainford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Etna Dr., Upper Marlboro, MD 20774 Joy J. Rainford / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 07/18/2011 Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Service Li ե500 Allentown Rd., Camp Springs, MD 20748 Part 1. Enter the disease, of complications that caused the death. Do us t enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 conths?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Yes 2 No Yes 2 25. Was case referred to medica 26. Place of Death (Check onl ne) examiner? Other: 2 No 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and fitle of cartifie

State Registrar

2 2 2011

eath (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/  $J_{\mathbf{u}}^{\text{Morth}}$  18, 9:44 Ам Linda Crandall Rawson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel 1351 Baltimore Annapolis Blvd. Arnold If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Months 7/97th 13.51ar) B8TTVia 214-52-9349 60 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Arnold 1 🗌 Yes 2 🕱 No Maryland Anne Arundel 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA Funeral 1351 Baltimore Annapolis Blvd. 21012 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 White f Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MD State Police Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Nora E. Gentile Gilbert A. Crandall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1351 Baltimore Annapolis Blvd., Arnold, MD 21012 Frank Rawson - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot 1 🗌 Burial 2 😨 Cremation 3 🗌 Removal from State Baltimore Crematory 7/19/2011 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee Mychin 147 Duke of Gloucester Street, Annapolis, MD 214Q1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Pnysician/ ∫™Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Days to for all a consequence of Cause (Disease or iinjury that the death certificate be executed that initiated events resulting in death) Last and-tran Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 month Month Day Pregnant at time of death 5 Other (specify) the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 9 Hospital or Attending Physician: The law requires to 24 hours after death.
9 Funeral Director: After this certificate has been sign 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed iis certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to prical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Griffying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 Certifying Nurse Pragtioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29d. Date signer (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

41715

Medical Partway Ste 210 Annapolis 31. Date filed (Month, Day, Year)

2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2011 25073

			State Registrar  1. Decedent's Name (First, Middle, Lasi	·)	Ce	rtificate c	f Death		2. Date of Dea	Reg. No.		3. Time of Death	
	Physicia Medic	al	KIMBERLY KAY		5				JULY	15 <sup>ay</sup>	201 Ĭ <sup>ear</sup>	9:56 A M	
	Examin	er	4a. Facility Name (if not institution, give HOLY CROSS HOS			SIL	n, or Location of VER SPRI	NG		4c. County of Death MONTGOMERY			
	Funeral Director		5. Social Security Number 214-80-5738  Usual Residence of Decedent	× 7. Age (In 4.	yrs. last birthday)  Yrs.	If Under 1 Y Months Da	ear If Under 2 ys Hours	Min.	B. Date of Birti (Month, Day JAN 14	1970	9. Birth	place (State or Foreign LAND	
land	show d at	h	10a. State 10b. County	10	c. City, Town or Lo	cation						10d. Inside City Limits	
Mary	28a-f notifie	Director	MD MONTGOM	ERY 1	BURTONSV							1 XYes 2 No	
/ith the	23a or st be r	ral	10e. Street and Number 3236 TAPESTRY CI	RCLE		10f. Zip Co.				USA	n of What Cou	ntry?	
J36 after death v	Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by F	11. Marital Status  1 🔯 Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates.		Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Ricar 1  Yes 2X No Specify:							
Maryland 27275-0036 2 should be filed within 72 hours after	e. Medical I	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Seconday (0-12)	lucation	(Give	dent's Usual Oo kind of work do OO NOT use reti	ne during most	of working	,		of Business In	ndustry	
Z withi	ygiene her th it, the	l on l		2	REN'	ral age					VATE		
and be file	ked ot ic ever	To B	17. Father's Name (First, Middle, Last) WILLIAM A. REYNO	LDS				,	First, Middle, THOMA		<i>ma</i> me)		
Mary 12 should	alth and M 27 is mar r traumat		19a. Informant's Name/Relationship (Ty MARY L. STONE/MO		19b. Maili 323	ng Address (Street and Number or Rural Route Number, City or Town, State, Zi 5 TAPESTRY CIRCLE BURTONSVILLE, MARYI						Code) AND 20866	
<b>Saitimore,</b> permit. Page 1 and	nt: If item		20a. Method of Disposition 1     Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)	Removal from State	20b. Place of Disponentery, cre MD NAT	matory or other	place)	Da 7/25/	- 1		ation - City or T		
Dart. Permit. F	Departm Importa any inju		21. Signature of Funeral Service Licens		L HOME,INC AND 20785								
	nysician/ Medical xaminer	ıer	23a. Part 1. Enter the disease, or companies shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. SEPTIC  Due to (or as a co  RENAL F  Due to (or as a co	SHOCK snsequence of): AILURE	er the mode of	dying, such as c	cardiac or	respiratory ari	rest,		Approximate Interval Between Onset and Death	
ficate be executed	physician and s the burial-transit	edical Examiner											
death certif	ed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown	23c. If yes, outcome of p 1  Live Birth 2 4  Pregnant at tin 9  Unknown	Fetal death 3	Ectopic pred Other (speci				23	3d. Date of deli Month	very Day Year	
IS, P.O.	been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but r	not resulting in the	underlying cau	e given in Part I					the cause of death? obably 4 🖾 Unknov	
DIVISION OF VITAL MECONDS, P.O. To the Hospital or Attending Physician: The law requires that the	ate has beer page 2 shou	Completed									prior to c death?	opsy findings available ompletion of cause of 2X	
cian:	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital: 32			6. Place of Deat	h (Check	only one)				
I OI VI	Affer this o	ate: To	1 Yes 2 LXNo  27. Manner of Death  1 XNatural 5 Pending	1 A Inpatient 28a. Date of injury (Month, Day, Ye	2 ER/Outpatie 28b. Time of injury	of 28c.	Injury at work?	2	ne 5 Resi 8d. Describe l		Other (Speci	<u>[fy]</u>	
JIVISIOI al or Attend	within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined		- At home, farm, si Specify)				8f. Location ( City or Tov		Number or Rur	al Route Number,	
L e Hospita	n 24 hours se Funera sleted fille	Medical	(Check 2 Medical Exam)	sician: To the best of my ner: On the basis of exam se Practioner: To the bes	nination and/or inve	stigation, in my	pinion, death oc	curred at t	the time, date a	and place, a	and due to the c	:ause(s) and manner sta	
To th	within To the comple	-	29b. Signature and title of certifier			29c. Li	cense number			29d. Date	signed (Month	, Day, Year)	
0	~		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type,	Print)				14 D***	ANTO OO	010	
		1	JONATHAN M. DUR	AND TEN	O EODECT	CTEM D	AD CITY	VER S	PRING.	MARYT	.AND 70	w III	

11-05658	
Joseph Reagan	

1-05658 Ioseph Reagan	Please Type or Print in Black Indelible State of Maryland / Department of	Ink. Ensure All Copies of Health and Mental Hyd	Are Legible. 2011 2507L
, ,	1- For State Certificate C	of Death	Reg. No.
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)		Date of Death Month Day Year July 29, 2011  3. Time of Death 0925 hrs
	4a. Facility Name (if not institution, give street and number) 4509 Maple Road	4b. City, Town, or Location of Death Suitland	4c. County of Death Prince George's
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  5. 78 - 7. 2 - 8.5.2.3 1 M 2 F 4.3 Yr	Months Days Hours Min.	6. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
aryland 8a-f show any at once. ector	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca  MD Prince Georges Mornings		10d. Inside City Limits  1
h the Maryland 3a or 28a-f sh totified at once		20746	USA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at oucc.  To Be Completed by Funeral Director	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes. Give Year	/as Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ric	
hours aft  Examine  Led by		ent's Usual Occupation (Give kind of work most of working life. DO NOT use retired)	
5-0036 ed within 72 hour bygiene. other than "nate the Medical Exa	12th Iron	n Worker	Private Industr
215-0 215-0 be filed w mtal Hygiv cut, the l			rst, Middle. Maiden Surname)
MD 21215-0036 to 2 should be filed within 7 lith and Mental Byggiene. In 27 is marked other than aumatic event, the Medical To Be Comple	19a. Informant's Name/Relationship (Type, Print )  19b. Mailin	ng Address (Street and Number or Rura	al Route Number, City or Town, State, Zip Code)
h, MC and 2 sl lealth ar tem 27	20a. Method of Disposition 20b. Place of Dispo	osition (Name of cemetery, D.	ingside, Md 20746 ate 20c. Location - City or Town, State
MOFE Pages 1 ent of H unt: If i	1 Burial 2 Cremation 3 Removal from State crematory or C 4 Donation 5 Other Specify:		/2011 Suitland, Maryland
Baltimore, permit. Pages I ar Department of Hec Important: If ite Imjury or other tr	21. Signature of Funeral Service Licensee 22.		111 A AVE,Suitland MD
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.		
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	one Intoxication	Death
	Sequentially list conditions, b	-	
ted is insit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in litated events resulting in death). Last events resulting in death). Last		
executed an and all - transit	«		
O, s be execut rsician and burial - tra		er me,g918 8-11-11	
ox 68760, ath certificate be attending physici or use as the burities of the purities of the purit	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery  Month Day Year
O. Box (at the death ce laby the attendiached for use	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
S, P.( juires that an signed ld be deu			1 Yes 2 No 3 Probably 4 Unknown  24a, Was an 24b, Were autopsy findings available
Records, The law requires ficate has been sig. page 2 should be			autopsy performed?  1  Yes 2 No 1 Yes 2 No
Vital ysician: this certi director	25. Was case referred to medical examiner? [Hospital: a largetiset 2 FD/Outpeties	26.Place of Death (Check only nt 3 DOA Other,4 Nursing H	
ding Ph. L. After ti funeral	27 Manner of Death 282 Date of Injury 28h Time of	1 Vas 2 Va No III	d. Describe how injury occurred
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transitedical Certification: To Be Completed by Physician/Medical Exhalical Certification:	Pending Investigation Could not be determined  5 Pending Investigation 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc. 28	f. Location (Street and Number or Rural Route Number, City or Town, State)4509 Maple Rd. 11tland, Md.
Divis  To the Hospital or within 24 hours after To the Foueral Dire completely filled in b		urred at the time, date and place, and due	e to the cause(s) and manner as stated.
H » F »	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year)  July 30, 2011
	30. Name and address of person who completed cause of death (Item 23a)		
State	Jack Titus MD. Deputy Chief Medical Examiner 900 W.  31. Date filed (Month, Day Year)  32. Registrar's Signatur  33. Registrar's Signatur		ID 21223
Registra			

1-05395		Please Type or Print in Black Indelible Ink					
iane Clarisa R		State of Maryland / Department of H		nd Mental F	-	201 Reg. No.	1 25075
Physici		Registrar  1. Decedent's Name (First, Middle,Lest)			2. Date of De Month	ath	3. Time of Death
dedical Exami	ner	Diane C. Renzi			July 19, 2		0353 hrs
			•	or Location of Deat	h	4c. County of D	
			othian	15		Anne Arun	
Funeral Director			Months Da			9. 14,1961	Birthplace (State or preign New York Country)
h		Usual Residence of Decedent  10a State 10b County 110c City, Town or Location					10d. Inside City Limits
w any		10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Lothian					1 Yes 2 No
with the Maryland is 23a or 28a-f show be notified at once.	ţ		Of. Zip Code			10g. Citizen of What (	
e Mar or 28,	Director	5602 Bounty's View Lane	2071	1		USA	outing :
ith th	_			lispanic Origin? ( S	pecify Yes or N		merican Indian, Black,
ath w	Funera	1 Never Married 2 V Married Armed Forces? If Yes,		an, Mexican, Puerto		White, et	
fler de		3 Widowed 4 Divorced If Yes, Give Yaar 1 Ye	s 2 X N	o specify:		Specify: W	hite
ours a	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Laborator of the complete of				16b. Kind of Busine	ss/Industry
6 172 h	lete	Elementary/Secondary (0-12) College (1-4 or 5+) 4 Administ	250	e. DO NOT use re	urea)	E-41	D
Medi	Completed		LIALUI		- (C) A BAT	Federal	reserve
1215-0036 doe filed within 72 houfental Hygiene, arked other than "natterent, the Medical Exa	Be Co	17. Father's Name (First, Middle, Lest)  Karl Thomas		Renate		, Maiden Surname) Mann	
21215-(1036 within 7 Mental Hygiene. marked other than cevent, the Medica	0 8		idress (Stre			ımber, City or Town, S	tate, Zip Code)
nd 2 hould be filed within 72 hours after death with the Maryland ealth and Mental Hygiene.  tem 27 is marked other than "natural", or items 23a or 28a-f abter traumatic event, the Medical Examiner must be notified at once		Rico P. Renzi/Husband 5602 Box	unty's	View La	ne. Lot	hian, MD 2	0711
Baltimore, MD 21215-100; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		20a. Method of Disposition 20b. Place of Disposition	(Name of c		Date	20c. Location - City	or Town, State
A O Pages ant of a cothe		1 Burial 2 X Cremation 3 Removal from State Kalas Crema 4 Donation 5 Other Specify:	tory	7/2	6/2011	Edgewater	r, MD
Baltimore, permit. Pages I as Department of Hes Important: If its		21. Signat of Funeral Sirvi Liu see 22. Nam	e and Addre	ss of Facility e C	rge P.	Kalas Fune	eral Home
E L A B	file					Edgewater	, MD 21037
Physician /Medical		23. P 11. Enter the disease, or complication, that caused the death. Do not enter the n failure. List only one cause on each ine. Multiple Injuries					Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease a. Intoxication	villó		17.35 h.f.o.		Death
		b					
	ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):					- 21
	閬	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a consequence of):					-
kecuted	Exa	events resulting in death) Last Due to (or as a consequence or):  d.					
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876( ficate g phy:	an/Med	IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal of Female 23c. If yes, outcome of pregnancy	teath 3	Ectopic pregn	ancv	23d. Date of deli Month	very Day Year
ox 687 eath certific attending p	Cia	past 12 months?  4 Pregnant at time of death 5 Other	(Specify)		and,		22,
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ires that the signed by detache	by P	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause	given in Part I.			o to the cause of death?  Probably 4 Unknown
S, H quires en sign ald be					24a. Was		autopsy findings available
cords law requir has been 2 should	ple			<del></del>	auto		to completion of cause of
tal Rec cian: The l certificate l ector, page	Completed				1 Yes		
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1 of Vi ling Physic After this	ပ	1 Yes 2 No Prospital: 1 Inpatient 2 ER/Outpatient 3  27. Manner of Death 28a. Date of Injury 28b. Time of Injury		ury at Work?	ng Home 5	how injury occurred	uler. Scene
ion c tending eath. for: Aft	ertification:	1 Natural 5 Pending 7—19—2011 Fd 3.46a		Yes 2 No	driver	r involved	in collision
r Atte er dea irecto	fical	28e Place of Injury - At home, farm, street, fa		building, etc.	28f. Location	(Street and Number or	Rural Route Number, City
Divisior oppital or Attend hours after death neeral Director:	erti	Suicide  Suicide  Suicide  Specify  Spe			34 Mul	State) <b>Len Lane,</b> ]	Lothian, Md.
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	ical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation,					
To 1 To 1	Medical	and manner stated.  29b. Signature and title of certifier		se number		29d. Date signed (	
h		QuiT?	0.0	.M.E.		July 19, 2011	
P		30. Name and address of person who completed cause of death (Item 23a)					
`		Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimo	ore Street	, Baltimore, M	D 21223		
	_						

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-05653 State of Maryland / Department of Health and Mental Hygiene William Marshall Rowles 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 29, 2011 Rowles 0040 hrs Marshall **Medical Examiner** William 4b. City, Town, or Location of Death 4c County of Death 4a. Facility Name (if not institution, give street and number) Allegany Western Maryland Regional Medical Center Cumberland If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. 46 Months Days Hours 10/06/1964 220-72-7194 Country) Director 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location H 10a. State 10b. County 1 Yes 2 X No Flintstone Allegany Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.

ant: If iten 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21530 12616 Murley's Branch Road, NE 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Funera 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2X No Yes White 1 Yes 2 No specify: If Yes, Give Year Specify. 3 Widowed 4 Divorced <u>ā</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Printing Operator Baltimore, MD 21215-0036 Comp 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Buckey Sandra Rowles, Sr. Jack Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MP<sub>530</sub> 12616 Murley's Branch Road, NE, Flintstone, Ruthie A. Rowles / Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Cumberland, MD 07/30/2011 Cumberland Crematory rtant: Donation 5 Other Specify 22. Name and Address of Facility Adams Family Funeral Home, P.A. Signature of Funeral Service 21502 404 Decatur Street, Cumberland, MD Approximate Interval 23a. Part Nenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** en Onset and failure. List only one cause on each line /Medica Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Sa AMENDED 23a,27 per me g918 8-10-11 vt attending physician a **X** UNPENDED Physician/Med Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If ves. outcome of pregnancy IF FEMALE 3 Ectopic pregnancy 23b. Was decedent pregnant in the Day Year 1 Live birth Fetal death signed by the attending be detached for use as t 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown <u>6</u> Completed 24b. Were autopsy findings available 24a, Was an page 2 should this certificate has been autopsy prior to completion of cause of performed? ✓ Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🔲 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification 1 X Natural 1 Yes 2 No death. 5 Pending Director: Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be hours after Suicide or Town, State) determined (Specify) 4 Homicide To the Funeral 29a. Certifier 1 Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medica one) and manner stated 29d, Date signed (Month, Day Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

OCMF 2006

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

July 29, 2011

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD

Date filed (Mosth 2011 (Par))

AUG 05 2011

11-05537

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Rodger Dwayne S	_	leton - For State	State	of Maryla	and / De	partment Certificate	of He	alth and ath	Mental Hy			201	1	25077
Physicia		Registrar 1. Decedent's Name (First, M	fiddle,Last	:)		ocitinoato	0, 00			2. Date of De			3.1	ime of Death
Medical Examin	er	Rodger	$D_{7}$	wayne	Sin	gleton	T	71	tion of Dooth	Month July 25, 2		Year		0615 hrs
)	ı	4a. Facility Name (if not insti Meritus Medical Co		e street and nu	imber)			gerstown	ocation of Death			Washington		
Funeral	7	5. Social Security Number	6. Se	x	7. Age (In y	rs. last birthday	_	Inder 1 Year	If Under 24Hrs	_	irth (MM	/DD/YYYY) 9. I	Birthpla eign	ce (State or
Director	1	217-90-5318	1X	M 2 F	3	3	Yrs. Mo	onths Days	Hours Min.	Augus	t 17	,1977	Country	) Maryland
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fler de		3 Widowed 4	Divorced	If Yes, Give Yes or Dates:	ar 2 tal 19	1	Yes	2 X No	specify:			Specify:	Wh	ite
ours a	ğ	15. Decedent's Education		nly highest gra					on (Give kind of v DO NOT use reti		16b.	Kind of Busines	ss/Indus	stry
16 n 72 h	Set	Elementary/Secondary (0	-12)	College (	1-4 or 5+)	We1		-			M	etal Fal	hri	ration
OO3 withi	Completed	17. Father's Name (First, Mi	ddle Last)	_		MET	uei	11	8.Mother's Name	e (First, Middle			<u> </u>	- Cat I on
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Kyle Single							Cather	ine Ro	bin	son		
213 ould b d Men d Men ic ever	2	19a. Informant's Name/Rela	tionship (T	ype, Print )		17			and Number or I					
MD d 2 sho lith and n 27 is		Dawn Singleto	on/Wi	fe		843			Laurel	Road B		Sboro, I		21713
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition  1 X Burial 2 Crem	ation 3	Removal fi	_	crematory o			-			·		
imc Page ment or oth		4 Donation 5 Oth	r Specify:	01		Mt. Lena								laryland
Baltimore, eemit. Pages I an Department of He Important: If ite	ļ	21. Signature of Juner of Se	Mice Licefi	of lot	21				ational					Home, PA
Physician	-	23a. Part I. Enter the diseas	e, or comp	dication that o	used the d	eath. Do not ent	er the mo	de of dying, s	such as cardiac o	or respiratory a	rrest, sh	nock, or heart	A	pproximate Interval
Medical	ļ	failure. List only one c		ach line/ Multiple Inj	uries									Between Onset and Death
Examiner	-	Immediate Cause (Final dis or condition resulting in dea		Due to (or as		ice of):								
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0, : be executed sician and burial - transit	dical	UNPENDED		AMENDED				_					+	
50, ate be or hysicia		IF FEMALE:	23c. If yes, outcome of pregnancy						10.00		2:	3d. Date of deliv	very	
6876( certificate nding physe as the b	an/	23b. Was decedent pregnan past 12 months?	t in the	1 Live		2	Fetal de		Ectopic pregna	ancy		Month	Day	Year
Box 68760 e death certificate b the attending physic	Physician/M	1 Yes 2 No 9	Unknown			or death 5	Other (	Specify)			- 14			
m : 421	된	Part II. Other significant c	onditions			not resulting in t	he underl	lying cause gi	iven in Part I.					cause of death?
s, P.O. uires that the signed by to doe detached	d b									1 Y	'es 2			y 4 Unknown
ords,	lete									24a. Wa aut	is an opsy	prior	to comp	sy findings available pletion of cause of
of Vital Records, P. B. Prysician: The law requires the there this certificate has been signed meral director, page 2 should be do	Completed										formed?			2 No
Vital Rec ysician: The his certificate director, page	BeC	25. Was case referred to m	-						of Death (Check					
Vita hysicia this ca	0	examiner? 1 ✓ Yes 2 No	. ]			2 🗸 ER/Outpa			Other Nursi				ther:	and a
ing Pt	n: T	27. Manner of Death  1 Natural 5		28a. Date Jul 25.	e of Injury h. Day,Year) 2011	28b. Time 0529 hrs		1	y at Work? ′es  2 ✔ No	Operator of	of mot	njury occurred orcycle that	collic	led with a
Sior Attend death ector:	catic	2 Accident	Pending Investigati	ion		At home, farm,	etroot fac			motor veh		and Number or	r Rural	Route Number, City
Division tal or Attendir rs after death. al Director: A	Certification:	3 Suicide 6	Could not determine	be		Road / High		ory, orned be	anding, oto.	or Town NB Route 6	State) 6 to EE	3 70 ramp, Hä	agensto	wn, MD
Tospit 1 hour 1 hour		4 Homicide 29a. Certifier 1 Certify	na Physic					t the time, da	te and place, and				7	
Division of Your Hospital or Attending Phywithin 24 hours after death.  To the Funeral Director: After to completely filled in by the funeral	Medical	(Check only one) 2 Medica	l Examine	r:On the basis	of examinat	ion and/or inves	tigation, i	n my opinion,	death occurred	at the time, da	te and p	place, and due to	o the ca	ause(s)
1 × 1 8	Σ	29b. Signature and title of o						29c. License			- 1	. Date signed (	Month,	Day, Year)
CZ		Un hi July 26, 2011									ly 26, 2011			
-		30. Name and address of p	erson who	completed car	use of death	(Item 23a)	more C	troot Pali	imore, MD 2	1223				
/	od-	-	V1	22 5	egistrar's Si	apature -				1225				
St Regist	ate rar	July,	8721	TOTAL DE	ساستورين	B. 19	bark							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-05457 State of Maryland / Department of Health and Mental Hygiene 25078 2011 Dennis Wayne Shank 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Da July 21, 2011 1014 hrs Medical Examiner Shank Dennis Wayne 4c County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Hagerstown Meritus Medical Center 5, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreian Days Hours Months Country)Maryland Director 1 X M 2 F 09/30/1954 56 218-62**-**7860 Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 X No Maryland Washington Boonsboro death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 19767 Lappans Road 23a noti 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 X Married 1 X Yes Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after c
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", o
injury or other traumatic event, the Medical Examiner n 4 Divorced of Pates: 1981-1983 Specify: 1 Yes 2 X No specify: White 3 Widowed <u>გ</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Agriculture Farmer 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Martha Howe11 Shank <u>Jane</u> Eugene Edward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ 19a. Informant's Name/Relationship (Type, Print) 9767 Lappans Road, Boonsboro <u>Maryland 21713</u> <u>Rebecca Sue Shank/Wife</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 07/26/2011 4 Donation 5 Other Specify. Stauffer Crematory Frederick. 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A nature of Funeral Service 7606 Old National Pike, Boonsboro, Maryland 21713 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Medical Death a. Contact Gunshot Wound of Chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED e attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death 2 past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been ector, page 2 should 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? perform<u>ed</u> Yes 2 No 1 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: this 1 Yes After t 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Subject shot self FOUND: 1 Natural 1 Yes 2 ✔ No 5 Pending Director: 0645 hrs Jul 18, 2011 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be or Town, State) 7130 Wheeler Road, Boonsboro, MD To the Hospital owithin 24 hours al determined (Specify) Residence 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number July 22, 2011 O.C.M.E.

フル - 5 State Registrar

ORIGINAL

egistrar's Signatu

900 W. Baltimore Street, Baltimore, MD 21223

ac

**OCME** 

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

31. Date filed (Morph Pay 28 20)

DHMH 17 Rev 1/2001 OCMF 2006 11-05404 Be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

etty Shank		State of Maryland / Department of Health and Mental Hygiene Certificate of Death
Physicia	n/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year
edical Examin		Betty Jean Shank  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
		Meritus Medical Center Hagerstown Washington
Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Mary Land
Director	L	214-32-4012 1 M 2 A F // 11s.   July 20,1933
any	F	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	١	Maryland Washington County Hagerstown 1 □ Yes 2 ☑ No
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  nat: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  616 Beaver Creek Rd. 21740 U.S.A.
with the s 23a o		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
death or item	Funeral	1 Never Married 2 Married 1 Yes 2 No  1 Ves 3 No  1 Ve
s after rral", o	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:  1 Yes 2 No specify: Specify: White  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done)  16b. Kind of Business/Industry
72 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)
5-0036 led within 72 Hygiene. other than		
21215-0036 uld be filed within 7 Mental Hygiene, marked other than	မ္မ	17. Father's Name (First, Middle, Last)  Fred John Faith  Margaret Irene Murray Faith
AD 21215-0036 2 should be filed within h and Mental Hygiene. 27 is marked other than mastic event, the Medic	2	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
e, MD 1 and 2 sho Health and item 27 is		Ralph L. Shank, Srhusband 616 Beaver Creek Rd. Hagerstown, MD 21740  20a. Method of Disposition   20b. Place of Disposition (Name of cemetery,   Date   20c. Location - City or Town, State
Baltimore, Mf permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		1 Burial 2 Cremation 3 Removal from State Crematory or other place)  Posso Hill Competency 7-10 2011 Hecometers MD
altim mit. Pa sartmen portant	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas Fiery Funeral Home
		1331 Eastern Blvd North Hagerstown, MD 21742
Physician Wedin		failure. List only one cause on each line.  Between Onset and Death  Death
Examiner	1	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):
	اي	Sequentially list conditions, if any leading to immediate  Due to (or as a consequence of):
	Examiner	cause. Enter Underlying Cause
ited J unsit	Exa	events resulting in death) Last Due to (or as a consequence of):
10, e be executed ysician and burial - transit	edical	UNPENDED AMENDED
760; ficate b		FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box 6876( e death certificate the attending phy-	iciar	past 12 months?  4 Pregnant at time of death 5 Other (Specify)
<b>ш</b> % च छ	Physician/N	1 Yes 2 No 9 V Unknown 9 Unknown 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?
ires that the signed by I be detach	à	1 _ Yes 2 ✔ No 3 _ Probably 4 _ Unknown
rds, require been si been si should b	ompleted	24a. Was an autopsy findings available autopsy prior to completion of cause of
Reco	ошо	performed? 1 Yes 2 No 1 Yes 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?  1 Vas 2 No
n of Vil ding Physic After this funeral dir	리	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ion c tending eath. for: Aft	rtion.	1 Natural 5 Pending Jul 10, 2011, Year) UNKNOWN 1 Yes 2 No Subject fell down stairs
Division of Vital Records,  To the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Rural Route Number, City or Town, State)
Cospital thours unerally filled		29a. Certifier 4 Certifier Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Divisi To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical	one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
E3E8	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		Mli Brasself, ME
JW-6		30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
S	tate	31. Date filed (Month, Day, Year) 32. Redistrar's Signature
Regis		ORIGINAL
DHMH 17 Rev 1/2	COOT	OCME ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink fingus All for Print i for State Registrar Reg. N2 0 25080 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 Vear Snavely, Jr. Joseph Christian Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. Sex 1X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Sept. 3, 1922 Pennsylvania 88 168-16-2005 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be markfuld once. 10a. State 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2X No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12015 Belvedere Road 21742 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican. etc.) 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Garden Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph C. Snavely Jennie Mae Leininger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Christian Snavely III/Son 953 Nelson St., Chambersburg,  $\mathbf{P}\mathbf{A}$ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 7/27/2011 Hagerstown, MD 21. Signature of Funeral Service Licensee

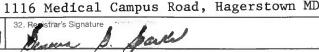
S'Mull Su 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only o Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner tic Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed -tran that initiated events resulting in death) Last Due to (or as a consequence of) inding physician use as the burial the burial Physician/Medical Division of Vital Records, P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred After 5 Pending iniury after death Director: A d in by the fi Accident Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after

To the Funeral Direcompleted filled in b City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of o 29c. License number 29d. Date signed (Month, Day, Year)

ブルー 6 + 1 State

Vladimir Rachmanin,
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:50A Marcus Shriver Jr. July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Golden Living Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 1) Feb 25 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 216-20-4787 1 XM 2 F 1924 87 Director ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Westminster 1 Yes 2 No Carroll MD 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21157 USA 54 W. Green St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married δ hours after Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.

7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Gas & Electric Designer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown unknown permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 54 W. Green St., Westminster, MD 21157 Beulah Shriver-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 7-21-11 Westminster, MD 4 Donation 5 Other (Specify) Westminster Cem. 22. Name and Address of Facility Fletcher Funeral 21. Signature of Francisco Licenses 254 E. Main St., Westminster, MD 21157 fremes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final SCVD Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying attending physician and for use as the bunal-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Live Birth 2 🗆 Fetal death Month in the past 12 months? Pregnant at time of death 2 🗆 No 1 Yes 2 9 Unknown sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate has 2 lle 2 🗆 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29d. Date signed (Month, Day, Year) 29b. Signature a 0 WIL STIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Redistrar's Signature

Pools RD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25082 State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year SAVOY FRANCIS DANIEL Medical Y.TUT. 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S 12506 CHALFORD LANE
Security Number 16. Sex BOWIE 7. Age (In yrs, last birthday) If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 □XM 2 □ F Months APRIL 14 MARYLAND 219-12-2727 **Director** 87 Isual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD PRINCE GEORGE'S FORESTVILLE 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7911 DANIEL DRIVE 20747 USA . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married à Yes 2 XNo Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 XNo Specify. "natural", 3 Divorced 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 6th CREW CHEF PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ WALTER SAVOY MARY B. PROCTOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 MARY M. SAVOY/WIFE 7911 DANIEL DRIVE FORESTVILLE, MARYLAND 20747 tem 20a. Method of Disposition 20b. Place of Disposition (Name of permit, Page 1 a
Department of H
Important; If ite
any injury or oth 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, RESURRECTION CEMETERY 7/20/2011 CLINTON, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Due to (or as a cor Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami that initiated events resulting in death) Last Due to (or as a cons burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 phy as IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe Yes 2 K No 1 Yes 2 K No Division of Vital 25. Was case referred to medical Be director, 26. Place of Death (Check only one) Hospital Group Home 2 🗓 No Other: 1 🔲 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No i 24 hours after dea h. e Funeral Director: After eleted fille in by the fun Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 

Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D006 H690

Registrar

DHMH 17 Rev 7/2009

State

7500 Mannover

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death HOSPITAL 4b. City, Town, or Location of Death Examiner OCKVIL MONTGOMERY 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Min. Month, Day, Yo Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City. Town or Location notified at the Maryland Funeral Director MD Yes 2 No 28a-f GAITHERSBURG 10e. Street and Number 10g. Citizen of What Country? ems 23a or r must be r 208 with t RAN items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 6 þ 1 Never Married 2 Married and 2 should be filed within 72 hours after Health and Mental Hygiene. tem 27 is marked other than "natural", or other traumatic event, the Medical Examiother Baltimore, Maryland 21215-0036 Specify: WHITE If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 횬 MOHAMAD 19a. Informant's Name/Relationship (Type, Print) DAUGHTES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AHEREH SAFAVI permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Place of Disposition , cemetery, crematory or other Burial 2 Cremation 3 Removal from State FREDERICK MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Lice see MUSLIM FUNERAL SER CODBRIDGE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tailure Physician/ respiratori disease or condition Medical resulting in death) Due to ras a consequence of) Examiner 2191 Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami tungemia and the burial-tran Due to (or as a consequence of): attending physician failure Physician/Medical ena Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Be Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cardiomen 24a. Was an autopsy performed? Yes 2 A-No page 2 dostridium difficle certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 2 No 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hankan D0055054 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 604 South Frederick Ave. Suite 409, Gaithersburn, Maryland 20877 MD Kasidi 32. Registrar's Signature ate filed (Month, Day, Year JUL 2 5 2011 Date filed (Month, State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 30 30 July Monti Mary Elizabeth Stroup 2011 1:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Citizens Care and Rehabilitation Center Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Hours 214-28-2369 1 M 2 X F May 12, 1925 Director 86 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1900 Rosemont Avenue 21702 United States of America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Health Care 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Edward Stunkle Lizzie Viola Fawley permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Stroup / Daughter 5500 Prince William Court, Frederick, Maryland 21703 Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from State Mount Olivet Cemetery August 2, 2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney & Rasford P.A. Funeral Home
106 Fast Church Street, Frederick, 21. Signature of Funeral M01433 Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury the agreement is a rest of out to and that initiated events resulting in death) Last Due to (or as a consequence of): -burialattending physician Physician/Medical certificate be Box 68760 as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year the Hospital or Attending Physician: The law requires that the death Day Pregnant at time of death 5 Other (specify) be detached signed by the 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 N Director: After this certificate has page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 🗌 Yes 2 🗌 No Investigation filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined hours Funeral Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie ၉ 10 gm on who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

AUG 0 5 2011

11-05639		or Print in Black					ible.					
Christopher James	1- For State	of Maryland / Dep	e <i>rtificate of l</i>		імента пу		20	11 25085				
Physician/	Registrar  1. Decedent's Name (First, Middle,La.					2. Date of Death	. 140.	3. Time of Death				
Medical Examiner	Christopher Jame	es Spiering				Month July 28, 20		1415 nrs				
O	4a. Facility Name (if not institution, gir Garland Road	e street and number)		Denton	ocation of Death		4c. County of Caroline	Death				
Funeral	5. Social Security Number 6. S	ex 7 Age (In vrs	. last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth		Birthplace (State or				
Director		M 2 F	52 Yrs.	Months Days		August 1		Foreign Country) Delaware				
	Usual Residence of Decedent					1 0	,					
w any	10a. State 10b. County		ty, Town or Location	n				10d. Inside City Limits  1 Yes 2 X No				
Maryland 28a-f show 1 at once.	Maryland Carolin  10e. Street and Number	e	Denton	10f. Zip Code		T 10/	g. Citizen of Wha					
the Maryland is or 28a-f sho wiffied at once Director	11420 Garland R	and			629	100	USA	a oddiny :				
with the sa 23a se 10th	11. Marital Status	12. Was Decedent Ever in	U.S. 13. Was	Decedent of Hisp	anic Origin? ( Spe	ecify Yes or No-	14. Race -	American Indian, Black,				
death with t r items 23s must be not	1 Never Married 2 Married	1 A Yes 2 No		s, specify Cuban,		Rican, etc.)	White,					
s after of	the state of the s	or Dates:		Yes 2 X No s Usual Occupation		adi dana	Specify: 16b. Kind of Bus	White				
5-0036 ed within 72 hours afti tygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	during mos	st of working life. I			100. Killu di bus	illess/illdustry				
036 thin 7: ne. r than redical	12 H.S. Grad	,	Aircrew	Surviva	al Equip	nentman	US Na	vy				
Hygie wi	17. Father's Name (First, Middle, Las	*)		118	8.Mother's Name	• , .	aiden Surname)					
1121 id be fill fental larked cvent,	Gene Carlyle Sp  19a. Informant's Name/Relationship (	iering	19h Mailing	Address /Street	Christ		er City or Town	Andrew , State, Zip Code)				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot injary or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Christine Spieri		•	•				nd 21629				
G, N I and Health item	20a. Method of Disposition	201	o. Place of Dispositi crematory or other	on (Name of cem				City or Town, State				
MOF Pages ent of unt: If	1 Burial 2 Cremation 3 4 Donation 5 Other Specific		apitol Cr		July	29, 2011	Dover,	Delaware				
talti mmit. I spartm porta	21. Sonature of Funeral Service Lice	79/	22. Na	me and Address	of Facility Mo	ore Fun	eral Ho	me, P.A.				
	23a. Part I. Enter the disease, or com	Marchine that sourced the doc						aryland 21629				
Physician /Medicar	failure. List only one cause on e	ach line. Atheroscl	erotic Ca	ardiovas	cular Di	sease w	Lth righ	Between Onset and Death				
Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence		Ly								
<u>_</u>	Sequentially list conditions, b.  Sequentially list conditions, b.  Due to (or as a consequence of):											
i i i i i i i i i i i i i i i i i i i	cause. Enter Underlying Cause (Disease or injury that initiated		s 01).									
ted Insit	events resulting in death) Last	Due to (or as a consequence	e of):									
ing Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and huneral director, page 2 should be detached for use as the burial - transt on: To Be Completed by Physician/Medical Examples and the Beach of the standard of	X UNPENDED	AMENDED23a,27,	per me,g9	18 8-11-	-11 sm							
). Box 68760, the death certificate be eay the attending physicial ched for use as the bural Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pr	_		7		23d. Date of c					
c 68 certification of the cert	past 12 months?	1 Live birth  4 Pregnant at time of		aldeath 3 _ er (Specify)	Ectopic pregnar	псу	Month	Day Year				
Boy c death the att	1 Yes 2 No 9 Unknow	9 UNKIOWII										
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u Completed by Physic		contributing to death but no	t resulting in the un	derlying cause giv	ven in Part I.			pute to the cause of death?  Probably 4  Unknown				
dis, F quires and be ted		<del></del>				24a. Was ar		/ere autopsy findings available				
of Vital Records,  of Physician: The law requires  ther this certificate has been sig- ineral director, page 2 should be  n: To Be Completed						autops perform	<u>ned</u> ? de	rior to completion of cause of eath?				
Rec i The ificate r, page	25. Was case referred to medical			26 Place	of Death (Check of	1 Yes 2	No 1	Yes 2 No				
/ital	examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient		Other Nursing		tesidence 6	Other: Scene				
of Vi	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Inj			28d. Describe ho	ow injury occurre	d				
ion trendii feath. for: / the fi	1 Natural 5 Pending 2 Accident Investiga	tion			es 2 No							
Division o spital or Attending fours after death. neral Director: After filled in by the fune Certification:	3 Suicide 6 Could no		t home, farm, street	, factory, office bu	ilding, etc.	28f. Location (St or Town, Sta		r or Rural Route Number, City				
lospita hours uneral dy fille	4 Homicide	cian: To the best of my knowl	edge death occurre	ad at the time, dat	e and place and	due to the cause	(s) and manner	as stated				
Division of Vital Rec To the Bospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page. Medical Certification: To Be Com	(Check only one) 2 Medicai Examine	er: On the basis of examination and manner stated.										
N S P S P S O	29b. Signature and title of certifier	and marrier stated.		29c. License	number		29d. Date signe	d (Month, Day, Year)				
	14t. Um.	Yollum		O.C.N	1.E.		July 29, 201	i1				
	30. Name and address of person who Patricia Aronica-Pollak M			000 W Baltim	ore Street R	altimore MD	21223					
State		32. Registrar's Sign		ad J								
Registra		2011	p. 194					·····				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2011 Month 15 Physician/ 8:50 A CHARLES LEROY TOMPKINS Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner MONTGOMERY BETHESDA NATIONAL NAVAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number . Age (In yrs, last birthday) Funeral Mar Month, 8 ay, Days Min. Hours Virginia 1 🔀 M 2 🗆 F 1943 68 Yrs. 223-54-1103 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 XNo Fairfax Alexandria VA 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 22309 4418 Neptune Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examitury or other traumatic event, the Medical Examit 1 ☐ Yes 2 X No Specify. If Yes Give 3 Widowed 4 Divorced Year or Dates. 1915-93 Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry during most of working College (1-4 or 5+) Elementary/Seconday (0-12) ommission Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alexandria Neotune 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a, Method of Disposition cemetery, crematory or other pl 1 Burial 2 Cremation 3 Removal from State 09 1201 Arlinsto 08 injury 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licepsee 22. Name and Address of Facility nelson E Greene 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final PROSTATE CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate case Entral Incert, ing Cause (Disease or iinjury Examiner Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year in the past 12 months? Pregnant at time of death 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed physician a s the burial-t Box 68760 P.O. Division of Vital Records, this certificate within 24 hours after death. To the Funeral Director: After

death

Baltimore, Maryland 21215-0036

Department of Health Important: If item 27

25. Was case referred to medical examiner? Hospital: Other: 1 ☐ Yes 2 😾 No

1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number

VILL

29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledd to Check only one)  Certifying Physician: To the best of my knowledd to Check only one)  Certifying Nurse Practioner: To the best of my kn	nd/or investigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s) and manner state
29b. Signature and title of pertifier	29c. License number	29d. Date signed (Month, Day, Year)

0102201805

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600

(VA)

LCDR MC USN KIM DANIEL

5 Pending Investigation

6 Could not be

determined

32. Register's Sign

Registrar

State

filled in by

မြ

Certificate:

Medical

27. Manner of Death

Accident

3 Suicide 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25087 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Tashna Ackeene Tomlinson 201 10:47AM™ July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death BETHESDA **Examiner** 4c. County of Death
MONTGOMERY NATIONAL INSTITUTES OF HEALTH 8. Date of Birth
(Month, Day, Year)
Dec. 7, 1978 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Jamaica Claredon, Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Director mme 32 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d Inside City Limits Director 1 🔀 Yes 2 🗌 No St. Catherine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 221 Port Ave. Jamaica 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates **Black** 1 Yes 2 x No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Joyce A. Campbell Roy Tomlinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Anderson / Husband Port Ave. New Harbor Village. St. Catherine Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 7/28/2011 Family Plot 4 Donation 5 Other (Specify Clarendon, Jamaica 22 Name and Address of Facility Alexander S. Pope, P.A. 2017 Pennsylvania Ave. S.E. Washington, Signature of Funeral Service Lice 1. Inter the disease, complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Tcell anaplastic ump homa disease or condition 3 years Medical resulting in death) Due to (or as a consequence of): **Examiner** cardiomopathy 48 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Pulmonary that initiated events resulting in death) Last Physician/Medical acute renal Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 2 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 🖳 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 24 hours after death Funeral Director: 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Definition Physician. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

D0669443

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

19.2011

, MD

Janice Leung
31. Date filed (Month, Day, Year)
JUL 2 2 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		1	For State	State of Maryland	d / Depa	rtment of F	lealth and N Death	1ental Hyg	iene 2 (		25088	
			Registrar  1. Decedent's Name (First, Middle, Last)		001	imouto of E	704177	2. Date of Dear	eg. No.		3. Time of Death	
Phys Me	iciar edica	_	GARY WAYNE WE	rzel –				July 23	. 2011	Year	12:18 P M	
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Fune Direct	_			M 2 $\square$ F 7. Age (In yrs. las	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 1	3.1945	Mary	place (State or Foreign try) Land	
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Tary should and h is me			19a. Informant's Name/Relationship (Type,	<i>'</i>		-	and Number or Rura					
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<b>Baltimore</b> , permit. Page 1 and Department of Hea Important: If item any iniury or othe	gj	ł	21. Signature of Funeral Service Licensee	1.00			ss of Facility Dou					
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			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of	ations that caused the death. cause on each line.	Do not ente	r the mode of dyin	g, such as cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death	
Pnysicia Medic		ı	Immediate Cause (Final disease or condition resulting in death)	Mecay	101	7A				_	Offiser and Death	
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X 68, h certific tending ir use as		an/	F FEMALE: 23b. Was decedent pregnant in the past 12 months?	:. If yes, outcome of pregnand 1  Live Birth 2  Fetal	death 3 _		;y			Date of deliv	1	
DIVISION Of VITAI RECORDS, P.O. BOX 68/60 with the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	1	Physician/Me	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of deg ☐ Unknown	eath 5 🗆	Other (specify)			P	Month	Day Year	
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he Ho in 24 h he Ful		Medical		: On the basis of examination a ractioner: To the best of my l								
Veith Voit Con 1			29b. Signature and title of certifier			29c. License	e number	, 2	29d. Date sign	ned (Month,	Day, Year)	
				DUL		003	5579	4	100	1,0	5,2011	
JW - 12	2		30. Name and address of person who com	pieted cause of death (Item 2	∠3a) (Type, Pi	I HA	JEAS .	AMPH	DA	217)	33	
	State	7	31. Date filed (Month, Day Year)	32. Registrar's Signatu	ire	4	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- 14 1 1				
Regi	stra		JUL 8 9 A	JIII Change	A	South !			_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#20bPerFHPG08-1-11cr Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2011 Physician 6:10 A M July 19, Catherine Julia Wilson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Nursing Home Prince George's Clinton. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖾 F 75 Yrs. Feb. 1936 Director 248-54-1847 19, South Carolina Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modest Exercited round to redified at 1 X Yes 2 □ No Director Temple Hills Prince George's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code United States 7201 Temple Hill Road 20748 Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 I Hygiene. Elementary/Secondary (0-12) 10th College (1-4or 5+) Government Secretary 12 should be filed with and Mental Hygier 7 Is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wallace Henderson Sr. Mary O. Vernon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20748 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 Is
any injury or other trau Debra Henderson - Daughter 7201 Temple Hill Road Temple Hills, Maryland July 28 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lee's Crematory Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature + Fu 4 ral Service Licenses 4001 Benning Road NE Washington, DC 20019 ema Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 mess Dispas **Physician** 4 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter or userlying Cause (Disease or injury Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the aid be detached f 1 ☐Yes 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page performed' certificate 1 □Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛂 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Matural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar (Check only

29b. Signature and title of certifier

lliam ANNERMA 11701 32. Registrar's Signature 31. Date filed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

206

Livingston

		•	1 - For State Registrar	State of Maryla		artment of H		_	giene Reg. 2.0		25090
	Physici		Decedent's Name (First, Middle, Las					2. Date of Dea	Day	Year	3. Time of Death 7:15а м
je.	/Medic Examin		Evelyn Anders 4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	July 1		nty of Deat	h
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	Funeral Director		5. Social Security Number 6. Se 577-24-9259	M 25xF 7. Age (m y.	rs. last birthday)  5 Yrs.	Months Days	Hours Min	n. (Month, Da	v, Year)	Co	nington, D.C.
	and *		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
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	e Hospitel of 24 hours at 8 Funsrel D	edicai C		ysician: To the best of my liner: On the basis of exam and manner stated.							
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	3		30. Name and address of person who						1	10	, 0.0 [/
		tė.	Dr. Raman Tuli 10	0810 Darnesto	own Rd.	#202, Ga:	ithersbu	urg MD 20	878		
	Sta Registr		JUL 2 2 2011	Denver B.	park						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar 2509 I Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 201<u>1</u> Physician/ July 15, 4:15 Geraldine Washington Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 15503 Jodphur Drive Bowie If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Month, Day, Yea Months Days Hours North Carolina 137-34-2896 Yrs 1940 Director 70 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a, State within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 No Bowie Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 15503 Jodphur Drive 20721 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? Black, White, etc. 1 Never Married 2 Married ò 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates **Black** "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Private 12th Clerical ye 1 and 2 should be filed wit t of Health and Mental Hygie If item 27 is marked other i or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lena Baker Sylvester Vaughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce M. Griffin - Sister 15503 Jodphur Drive Bowie, Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place)
Heritage
Lemorial Gardens permit. Page 1
Department of
Important: If it
any injury or o 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stewart Funeral Home, Inc. tun 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) **Examiner** Respiratory Failure Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒No Vear Month Day Pregnant at time of death 5 Other (specify) has been signed by the age 2 should be detached 9 Unknown Hnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate har ral director, page 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🗓 No 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မြ 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 环 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number July 20, 2011 MDH 00069994 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20762 Michael P. Kenney, Msj. USAF, MC 779 MDOS/SGOMI Andrews AFB, Md. 31. Date filed (Month, Day, Year) 32. Registr State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 1 | State of Maryland / Department of Health and Mental Hygiene 25092

David	Wa	vne	Will	iams
		,		

	1- For State Registrar		,		Certific	ate of l	Death		75	Reg	g. No.		
Physician Medical Examine	1. Decedent's Nam			7 A STATE		LITT	TTAMC		М	ate of Death	Day Yes	ar	3. Time of Death
Wedical Examine		AVID if not institution	on, give street end nu	VAYNE			LIAMS	r Location of		ily 13, 20	11 4c. County of	of Death	
	13207 Livin	gstone En	deavor Drive		Bowie					Prince George's			
Funeral	5. Social Security I		6. Sex		yrs. last bir	thday)	If Under 1 Ye			Date of Birth		9. Birt	hplace (State or n NEW YORK untry)
Director	073-60-		1XM 2 F	44		Yrs.			]	ULI Z	1907	Cou	untrý) EW TOTAK
any	Usual Residence of 10a. State	10b. County		10c	. City, Town	or Location						——Т	10d. Inside City Limits
	MD	PRINC	E GEORGE'S	s	ВС	OWIE							1 Yes 2 No
the Maryland or 28s-f sh tified at once	10e. Street and Nu			10f. Zip Code							g. Citizen of Wh	nat Coun	itry?
11215-0036 Id be filed within 72 hours after death with the Maryland Atental Hygiene. narked other than "natural", or items 23a or 28a-f showers, the Medical Examiner must be notified at once. O Be Completed by Funeral Director		IVINGS'	TONE ENDE			142 144-1	2072		i=0 / 0if-		USA	A	an Indian Block
leath with r items 23 111st be no	1 Never Marri	ed 2 M	arried Armed F				Decedent of Hi , specify Cuba				White		can Indian, Black,
s after de internal", or niner m	2 NAtidowed	4 X Div	orced If Yes, Give Yas or Dates:		1 Yes 2 X No specify:					Specify: BLA			ACK
hours a	15. Decedent's E		cify only highest grad				Usual Occupa of working life			ione	16b. Kind of Bu	siness/Ir	ndustry
5-0036 ed within 72 hour sygiene. other than "natu the Medical Exar	Elementary/Sec	ondary (0-12)	College (1			ENTRE	PRENEUF	}			PRIVA	TE	
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	17. Father's Name	(First, Middle,						18.Mother's	•		aiden Surname	)	
21215-( uid be filed a Mental Hygi marked oth	CLENTIS				Lan				ICIA F				
nd hou			S/FIANCE		191	о. машпд А 13207	LIVINO	et and Numb SSTONE	ENDE	Route Numb	er, City or Tow RIVE BO	n, State, )WIE	, MARYLAND
	20a. Method of Dis	position			20b. Place o		n (Name of ce		Date		20c. Location -		20/20
MOF Pages lent of int: If	1 X Burial 2 4 Donation 5	_	n 3 Removal fr	om State		•	EMETER	. I	7/21/	2011	T.ANDOY	VFR.	MARYLAND
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	21. Signature of Fu				HARM	22. Nar	ne and Addres	s of Fecility	J. B	. JENK	CINS FU	NERA	L HOME, INC.
Physician	23a. Part I. Enter th	ne disease, or	complications that c	aused the	death. Do no	747	4 LANDO	OVER R	ROAD H	YATTSV	ILLE,MA	ARYL.	AND 20785 Approximate Interval
Medical	failure. List on	ly one cause	on each line.		)		, ,	,					Between Onset and Death
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6	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):												
ted 1 Insit Examiner	cause. Enter Unde	erlying Cause hat initiated	C										
recuted and transit - transit		death) Last	Due to (or as a	conseque	nce of):								
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760, iicate be exe g physician the burial -		pregnant in th	23c. If yes,					Tratania.			23d. Date of		. Vos
Box 687  death certifithe attending and for use as the area of the	past 12 months	5?	4 Pregn	ant at time	of death 5	=	death 3 (Specify)	Ectopic	pregnancy		Month	D	ay Year
b. Box 68: the death certifi the death certifi oby the attending ched for use as I Physician	1 Yes 2 1		nown g Unkno									9	ha a sa a da a ta a
Division of Vital Records, P.O. B tal or Attending Physician: The law requires that the d its after death.  al Director: After this certificate has been signed by the led in by the funeral director; page 2 should be detached artification: To Be Completed by Physicians.	2000 100 200	mcant conditi	ions contributing to	death but	not resulting	g in the und	erlying cause	given in Pan	T I.			_	he cause of death? ably 4 Unknown
Records,   The law requires ficate has been signage 2 should be Completed									—   <sub>2</sub>	24a. Was an			opsy findings available
BCOF te law te has te has te has te mol									_	autopsy perform  Yes 2	ied? d	eath?	ompletion of cause of s 2 No
ital Recition: The conficate rector, page		red to medical					26.Place		Check only o		NO 1	V 10.	2 10
F Vita	1 ✔ Yes	2 No		npatient		utpatient 3					esidence 6		Scene
n of ding Ph. h. After t		h 5 Pend	28a. Date Jul 13, 2	of Injury Day,Year) 2011	28b. 1 1248	Fime of Inju 3 hrs		ıryat Work? Yes 2 ✔ 1	ISubi	Describe ho ect shot	w injury occurre	∌d	
isior Attender death	2 Accident	Inves	stigation 28e Place	e of Injury -	- At home, fa	rm, street,	actory, office I			ocation (Str	eet and Numbe	er or Rur	al Route Number, City
Division oppital or Attending tours after death.  neral Director: After filled in by the functor of the functor	3 Suicide 4 ✔ Homicide		mined (Specify)	Single	Family H	ome			1320	or Town, Sta 7 Livingsto	te) ine Endeavor	Drive,	Bowie, MD
8 - 2 > 1	29a Certifier		nysician: To the bes										
To the Ho within 24 To the Fore Complete!	29b. Signature and		and manner s	tated.		, - osugatioi	29c. Licens		uneu at tre t				
-		111			$\times$ $\wedge$ $\circ$						d. Date signed (Month, Day, Year)		
n /	30. Name an addr	ess of person	who completed caus	e of death	(Item 23a)	-							
R 6	Russell Alex				_		. Baltimore	Street, B	Baltimore,	MD 2122	23		
State	31. Date filed (Mon	th. On Year)	32. Re	gistra's Si	gna Fre							-	

			State of Maryland / De			nd Me	ntal Hygi	ene		
			1. Decedent's Name (First, Middle, Last)	ertificate of D	eath		Re Date of Death	g. No.2 0	++-	25093
	Physicia		Jung Ahn Yea				Month July		$1^{Y_{\mathbf{c}}^{ar}}$	4:01 P. M
•	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or		Death		4c. County	of Death	
	<i>j</i>		The Johns Hopkins Hospital	Baltimor				<u> </u>		
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🔯 F 67  7. Age (In yrs. last birthda	Months Days	If Under 24 Hours		Date of Birth (Month, Day,	19643		place (State or Foreign Korea
1			624-16-5853 67 Yrs Usual Residence of Decedent				,,,,	1743	Dout	Rozoa
	yland f sho	ctor	10a. State 10b. County 10c. City, Town or Maryland Prince George's Upper M							10d. Inside City Limits
	r 28a notifi	Director	10e. Street and Number	10f. Zip Code			1	og. Citizen of	What Cour	1 Yes 2 X No
	vith th 23a o st be		7305 Arbutus Terrace	20772				U.S.A		iu y :
	leath v	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hi     If Yes, specify Cubar	spanic Origin	n? (Specify	Yes or No-		ce - Americ	
36	after o	by	1 Never Married 2 M Married 1 Yes 2 M No	1 ☐ Yes 2 🛣 No		donto	uit, 010.7		ck, White, ·· <b>Asi</b> a	
9	hours natura ical E	lete	Year or Dates.  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working)  (Give kind of work done during most of working)							
215	iin 72 ie. han "r s Med	dwo	3 Widowed 4 Divorced   1 Yes, Give   1 Yes, Give   1 Yes 2 K No Specify:   Specify: Asian   Specify: Asian   15. Decedent's Education   16a. Decedent's Usual Occupation   Give kind of work done during most of working life. DO NOT use retired)   16b. Kind of Business Industry   16c. Do NOT use retired   16c. Cleaning/Alteration   16c. Cleaning/							
121	d with Hygien ther ti nt, the	a l	17. Father's Name (First, Middle, Last)	er	40.14-45	la NI (F				terations
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To E	Hong Sun Ahn		Yu	Soo	irst, Middle, M n Kir		e)	
ary	should be file and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street a	and Number o	or Rural Ro	oute Number, (	City or Town, S	State, Zip	Code)
Σ,	nd 2 s ealth a m 27 i			I Street,	S.W.A	Apt.6	16 Wash	ningtor	1, D.	C.20024
lore	ge 1a nt of H : If ite or oth		1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, o	sposition (Name of crematory or other plac		Date		20c. Location	•	
Baltimore,	artmer artmer ortant injury			1 Mem Park						, Virginia
Ba	permi Depar Impo any ir		21. Signature of Funeral Licens	22. Name and Address National F 7482 Lee H	uneral ighway	l Hom	e 11s Chu	irch, V	/irgi	nia 22042
П			23a Part 1. Enter the disease, or complications that caused the death. Do not shock, or leart failure. List only one cause on each line.							Approximate Interval Between
	Physician/		In mediate Cause (Final disease or condition Advanced Pancrea	itic Cancer						Onset and Death 4 Months
مسب	Medical Examiner		resulting in death)  Due to (or as a consequence of):							
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	death certificate be executed ne attending physician an ed for use as the burial-t uron	dical E	resulting in death) Last Due to (or as a consequence of):							
760	cate b	edic	d					-1		
89	certifi ending use a	an/N	F FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1	3  Ectonic pregnanc	V			23d. Da	ate of deliv	ery
Box 687	death he atte	Physician/Me	in the past 12 months?  1  Yes 2 X No 9  Unknown  9  Unknown  9  Unknown	5 Other (specify)	,			Mo	onth	Day Year
P.O.	requires that the death certifics been signed by the attending p should be detached for use as '		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause giv	en in Part I.		23e. Did tob	acco use conf	tribute to t	he cause of death?
S, F	uires the signer of signer	ed by					1 □ Ye	s 2 🛚 No	3 🗌 Pro	bably 4 🗆 Unknown
orc	iw requisits peel	Completed					24a. Was an autops		Were auto	psy findings available empletion of cause of
Rec	The law cate has page 2 s	Com					perforn 1  Yes 2		death?	
tal	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: Y		ace of Death	(Check or	nly one)			
of V	Phys	<u>ان</u>	1 Yes 2 A No 1 Inpatient 2 ER/Outpa 27. Manner of Death 28a. Date of injury 28b. Tim	e of 28c. Injury	4 🗀 Nurs		5 Reside			/)
ou c	ath. r: Afte	icat	1 X Natural 5 ☐ Pending (Month, Day, Year) injur 2 ☐ AccidentInvestigation	y work	? Yes 2□N			. ,		
Division of Vital Records,	or Atte fter de irecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, bullding, etc. (Specify)	street, factory, office		28f	Location (Str.		er or Rura	I Route Number,
Ö	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, dea	ith occurred at the time	date and nic	ace and d	ue to the caus	e(s) and man	ner as state	ed.
	n 24 h	Medical	(Check conly one) 3 Certifying Nurse Practioner: To the best of my knowledge, determined on and/or in the basis of examination and or in the basis of examin	vestigation, in my opinio	n, death occu	urred at the	e time, date and	place, and du	e to the ca	use(s) and manner stated.
	To the vithing to the complete		29b. Signature and title of certifier	29c. License	number			July	d (Month,	Day, Year)
	10		Now Jalen, m.D					эшту	0, 20	,
			30. Name and address of person who completed cause of death (Item 23a) (Typ Dan A. Laheru, M.D.1650 Orleans S	<sub>e,Print)</sub> treet, Balt	timore	, Mar	ryland	21231		
	Sta		31. Date filed (Month, Day, Year)  JUL 22 2011	and de						
	Registra	ar	JUL WA CUIT ( BOURS B. 19							

errell Austin		S1 1- For State Registrar	tate of Maryl		artment of rtificate of		nd Men	tal Hy	_	Reg. No	20	11	25094
Physicia	n/	Decedent's Name (First, Midd	fle,Last)					12	2. Date of De Month	ath Day	Yea	,	3. Time of Death
Medical Examin	ıer	Terrell Austir 4a. Facility Name (if not institution	on, give street and n	umber)	14	b. City, Town, o	or Location o	of Death	July 28, 2	2011	c. County c		2300 hrs
		Sinai Hospital	, ,			Baltimore				- 1	o. Ovanty o	Dodgi	•
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Ye		r 24Hrs.	8. Date of B	irth (MN	I/DD/YYYY		thplace (State or
Director		213-13-7308	1X M 2 F	24	Yrs.	Months Day	ys Hours	Min.	Oct. 5	5.19	86	Foreig Cou	untryMaryland
- b	- [	Usual Residence of Decedent  10a. State 10b. County			, Town or Location	n .					70		
_ \$						on							10d. Inside City Limits  1 X Yes 2 No
faryland 28s-f she	횽	Maryland 1  10e. Street and Number	1/A	Bal	timore	10f. Zip Code				10a Cit	tizen of Wh	at Cour	
th the Ma 23a or 28	Director											004	,.
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once		5501 Nelson Ave	12. Was De	cedent Ever in U		21215 Decedent of H				USA o-		- Amen	can Indian, Black,
death or iten	Funeral	1 Never Married 2 M	arried Armed F	orces?	If Ye	s, specify Cuba	n, Mexican,	Puerto R	ican, etc.)		White	, etc.	
ral", o	Q.		vorced If Yes, Giva Ye or Dates:	ar		Yes 2 X No					Specify:		
5-0036 led within 72 hours Hygiene. other than "natur	B E	15. Decedent's Education (Spe Elementary/Secondary (0-12)				s Usual Occupa st of working life				16b.	Kind of Bus	siness/li	ndustry
136 bin 72 e. than stical	De			1-4 or 5+)	T7					١.	. / -		
5-00 ed wit lygien be Me	Completed	12th grade 17. Father's Name (First, Middle,	, Last)		I uner	mployed	18.Mother	s Name (I	First, Middle,		/A Surname)	-	
21215-0036 Muld be filed within 7 Mental Hygiene, marked other than ic event, the Medica	B	Tyrone Andrew	Austin				Mich	elle	Clark				
hould by the street of the str	-1	19a. Informant's Name/Relations			19b. Mailing	Address (Stre	et and Num	ber or Ru	ral Route Nu	mber, C	city or Town	, State	Zip Code)
imore, MD 2 Pages 1 and 2 should nent of Health and Naut: If item 27 is not over other traumatic	ŀ	Michelle Austir 20a. Method of Disposition	n/ Mother	20h I	5501 I Place of Disposit	Velson A			timore	MD 200	2121	Sity or	Town, State
Ore Ses 1.2 Fight ther t		1 X Burial 2 Cremation	n 3 Removal f		crematory or oth		inotory,		Date	200.	LOCALION -	City Oi	Town, State
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other Sp 21. Signature of Funeral Service		Ki	ng Memor	rial Par	rk	8-06	-2011	Wo	odlaw	$n_{\bullet}M$	D al Home
Depa Depa injury		Stare. All	10cmsec			240 Reis							
Physician		23a. Part I. Enter the disease, or		caused the death.									Approximate Interval
/Medical Examiner		failure List only one cause Immediate Cause (Final disease		c Arrhyt	thmia								Between Onset and Death
-Xammer	1	or condition resulting in death)	Due to (or as a	a consequence o	f):								
	7	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence of	f)·	_							
	튑	cause. Enter Underlying Cause (Disease or injury that initiated	с										
Big & A		events resulting in death) Last	•	a consequence of	f):								
e be executed ystician and burial - transit	gical	X UNPENDED	d AMENDED 2	23a,pt.I	I,27,pe	r me.g9	19 9-2	29-11	Sm				
Box 68760, ne death certificate be the attending physician ted for use as the burian		IF FEMALE:		outcome of pregi		,8,				23	d. Date of	delivery	
lox 6876( leath certificate a attending phy-	<b>≅</b> I	23b. Was decedent pregnant in the past 12 months?	I LIVE I			al death 3	Ectopic	pregnand	y		Month		ay Year
OX leath c e atten for us	Physici	1 Yes 2 No 9 Unk	known 9 Unkn	nant at time of de own	atn 5 Oth	er (Specify)							XI
that the de detached f		Part II. Other significant conditi			esulting in the un	derlying cause	given in Par	t I.	23e. Did t	obacco	use contrib	oute to t	he cause of death?
ires that the signed by	9	Atrioventricu	lar nodal	artery	dysplas	ia;			1 Ye	s 2	No 3	Prob	ably 4 🗹 Unknown
ords w requi		Focal myocard:	ial inter	stitial	fibrosi	S			24a. Was				opsy findings available ompletion of cause of
leco he law ate has age 2 s	Completed				-					med?	de	eath?	_
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Be	25. Was case referred to medical examiner?		EAR		26.Place	of Death (						
Vit hysic r this	인	1 ✓ Yes 2 No		Inpatient 2 🗸					Home 5				
n of ding Ph		27. Manner of Death  1 X Natural 5 Pend		of Injury i, Day,Year)	28b. Time of Inj	· 1 _ ·	ry at Work?	- 1	3d. Describe	how inj	ury occurre	d	
Attender death	ᇙ		stigation	e of Injury - At ho	ome form street		Yes 2 1	-	of Location (	Ctro et a	and Mirror bar	. or D	Pouts Number City
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	€Ι.		d not be (Specify)		me, iaim, street	lactory, office t	bullaing, etc.		or Town, S		and Number	or Rur	al Route Number, City
Div To the Hospital or within 24 hours afte To the Funeral Div completely filled in		29a Certifier	nysician: To the bes		ge, death occurre	ed at the time, da	ate and plac	e, and du	e to the caus	se(s) ar	nd manner a	as state	d.
o the		(	miner:On the basis and manner s	of examination ar			-						
H 3 H 2	Ž∣	29b. Signature and title of certifie	r			29c. Licens	e number			29d.	Date signe	d (Mon	th, Day, Year)
		hyh		2		O.C.	M.E.			July	30, 201	1	
	1	30. Name and address of person				Chryst D. 11	lima e a a a a	D 045	22				
	40	Ling Li, MD Assistation  31. Date filed (Month, Day, Year)	nt Medical Exar	miner 900 \		Street, Ball	umore, M	2122	23				
Sta Registr	$\sim$	AUG 0 8 2011	A	- Signatu	hard								
DHMH 17 Rev 1/200	)1		/	1. 17	ORIGINAL								
OCME 2006									n	CME			

Donna McDowell	1- For State	State of Maryla		rtment of		d Mental		Reg. No. 20	11 25095
Physician/ Medical Examiner	1. Decedent's Name (First, Deana Olivia A		Olivia .	Allen Mo	Dowe11	_	2. Date of De Month August 1	ath Day Year	3. Time of Death
	4a. Facility Name (if not ins Northwest Hospita		ımber)	41	c. City, Town, or Randallstow			4c. County of Baltimore	
Funeral Director	5. Social Security Number 212–82–9440	6. Sex 1 M 2 X F	7. Age (In yrs. la 45	ast birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of B Min. 06/06,		Birthplace (State or Foreign     Country) MD
ate,	Usual Residence of Deceded 10a. State 10b. Co		*	Town or Location					10d. Inside City Limits  1 Yes 2 No
the Maryland a or 28a-f sh riffied at once	10e. Street and Number 332 North Bea	umont Avenue			10f. Zip Code	1228		10g. Citizen of Wha	at Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4		2X No	If Ye	Decedent of His s, specify Cuban	Mexican, Pu	(Specify Yes or N erto Rican, etc.)	White,	- American Indian, Black, etc. rican-American
5-0036 ed within 72 hours is tygiene. other than "naturn one Medical Exami	Elementary/Secondary (i	(Specify only highest grad 0-12) College (1 4		during mo	s Usual Occupati st of working life. nefit Aut	DO NOT use		16b. Kind of Bus SSA. Feder	al Government
MD 21215-0036 d 2 should be filed within 7 th and Mental Byggiene. n 27 is marked other than numatic event, the Medica To Be Comple	17. Father's Name (First, M Joseph James 19a. Informant's Name/Rela	Allen, Jr.		19h Mailing		Brenda	Joyce Hol	Maiden Surname) Iman Imber, City or Town	State 7in Code
MD 21 nd 2 should alth and Me an 27 is ma aumatic ex	James McDowel		Took 5	332 No	rth Beaum	ont Aven		ille, Maryl	
Baltimore, permit. Pages lar Department of Hee Important: If ite	20a. Method of Disposition  1 Bunal 2 Crer  4 Donation 5 Oth	nation 3 Removal fr	om State	Place of Disposit crematory or othe TO Cremat	er place) OLY		8/5/2011	Baltimor	re, Maryland
Balti permit. Depart Import injury	21/ Signature of Furieral Se	el	/	9200	Liberty 1	Road Rain	dallstown,	Maryland	
Physician Wedical Examiner	23a, Part I, Enter the diseas failure. List only one of Immediate Cause (Final dis	cause on each line. sease a. <b>Drowni</b>	ng		e mode of dying,	such as cardia	ac or respiratory a	rest, shock, or hea	rt Approximate Interval Between Onset and Death
e.	or condition resulting in de- Sequentially list conditions if any, leading to immediate	b	consequence of						
ansit Examiner	cause. Enter Underlying C (Disease or injury that initial events resulting in death)	ause c.	consequence of	·):					
e be executed vsician and burial - transit	<b>≭</b> UNPENDED	X AMENDED			per me,	g919 9-	-9-11 sm	lood Day - f	
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate t within 24 hours after death.  To the Functal Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the builedical Certification: To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 23d. Date of delivery Month Day Ye Other (Specify)								
P.O. I res that the signed by the detached by the detached by the detached by the detached by Ph	Part II. Other significant c	onditions contributing to	death but not re	esulting in the un	derlying cause g	iven in Part I.			oute to the cause of death?  Probably 4 Unknown
Records,  The law requires ficate has been sig page 2 should be Completed							1 ✓ Yes	opsy proof	Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No
Vital ystcian: his certif director,	25. Was case referred to m examiner?  1  Yes 2 No	Hospital:	npatient 2	ER/Outpatient		of Death (Che	rsing Home 5	Residence 6	Other:
n of Viding Physical  After this funeral differential dif	27. Manner of Death  1 Natural 5	28a. Date	of Injury , Day,Year)	28b. Time of Inj		y at Work? 'es 2 🗶 No		how injury occurre	
Division o  To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune ledical Certification:	2 Accident 3 X Suicide 6	Investigation III /	-29-11   e of Injury - At ho	fd 7:47 ome, farm, street residence	factory, office be		28f. Location	(Street and Numbe State) 7520	r or Rural Route Number, City
To the Hospi within 24 hou To the Funes completely fi	29a. Certifier 1 Certifyi	ng Physician: To the bes I Examiner: On the basis of and manner s	of examination ar				and due to the cau	use(s) and manner	
Me sigis	29b. Signature and title of c		ialeu.		29c. License				ed (Month, Day, Year)
Ø	30. Name and address of p	·			O.C.N		oltim cas BAD	August 3, 2	
State	Pamela E. Southa 31. Date filed (Month, Day,)		Medical Exar		vv. Baltimore	e Street, Ba	altimore, MD 2	21223	
Registrar		1 Conera	A. A.	ake					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup>2<u>011</u> Physician/ August 6. NANCY VIRGINIA MARKEY ACKLER 1:45P <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 702 Walker Avenue Baltimore Baltimore County Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F June 28 214-10-4768 95 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No Maryland Baltimore County Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 702 Walker Avenue 21212 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Stock Clerk Retail Sales Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Willard Markev Bertha LaRue Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois R.A. Abbott (Daughter) 891 Century Street, Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 8/11/2011 Frederick, Maryland 21. Si natu // Fy era Servi Aliches
Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** lical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

Records, P.O. Box 68760

Division of Vital

within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

Medical	Medical Certificate: To Be Completed by Physician/Mec	o Be	Complet	ed by	<b>Physicia</b>	in/Mec

Douglas 31. Date filed (Month, Day, Year)

AUG 0 8 2011

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a consequence of).  c. Due to (or as a consequence of):  d.						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year			
Part II. Other significant conditions co	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?  2 No 3 Probably 4 Unknown			
			24a. Was an autopsy performed? 1 \sum Yes 2				
25. Was case referred to medical examiner?		26. Place of Death (Cl	heck only one)				
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)			
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		ury occurred					
4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
(Check 2 Medical Examîr only one) 3 Certifyîng Nurs	ician: To the best of my knowledge, death ner: On the bests of examination and/or invo e Practioner:/To the best of my knowledge	estigation, in my opinion, death occurre	ed at the time, date and pla	ce, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier	ugfas Clarke	29c. License number  A) D00314	76 29d. E	Date signed (Month, Pay, Year)			

DHMH 17 Rev 7/2009

State

Registrar

me and address of person who completed cause of death (Item 23a) (Type, Print)
uglas Clark, MD, 7505 Osler Drive, #214, Towson, Maryland 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 145 PM TEVEN 7 011 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 XM 2 F 5-3-1957 212-76-4710 54 S CAROLINA Director Usual Residence of Decedent 10d, Inside City Limits 10a, State 10b. Count 10c. City, Town or Location show Yes 2 No BALTIMORE Director RASPEBURG 7 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21206 4909 BENION HEIGHTS AVENUE U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: 1980 – 85 . Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ No WHITE Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. 12 HEAD DISPATCHER MARYLAND CONCRETE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental H 1 and 2 should be GRETA ELAYNE ARNDT **EDWARD** JOSEPH ADAMS 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARLA JEAN ADAMS/WIFE 4909 BENTON HEIGHTS AVE BALTO., MD 2120€ of Health 27 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If It any Injury or o 1 Burial 2 Cremation 4 Donation 5 Other (Specify) 8-5-2011 CATONSVILLE, MD METRO CREMATORY 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee ROSEDALE, 21237 CHESACO AVE 1211 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Day ? >EPSIS **Physician** /Medical Due to (or as a consequence of): Examiner Dayslwei TEREMIT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of). attending physician Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Tectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) n signed by the at uld be detached for 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. <u>≽</u> 4 Unknown 1 Yes 2 No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 🗌 No 2 🗌 No Yes Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 No 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28b. Time of 28d. Describe how injury occurred 27. Manger of Death Certification: 1 Natural Iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the f 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide determined

PO. Records. Division of Vital

of or Attending F s after death. 24 hours Hospital To the within 2

> State Registrar

31. Date filed (Month, Day, Year) AUG 0 8 2011

29b. Signature and title of certifie



and manner stated.

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

Medical

29a. Certifier (check only

mr

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Joy Gayle Albright 2011 25098 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2 Date of Death 3 Time of Death Physician/ Month 1922 hrs August 1, 2011 Medical Examiner Joy Gayle Albright 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death **Baltimore County** Baltimore 6805 Barnett Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Months Hours Director Sept 30, 1947 Country Maryland 212-50-2134 2 X F 63 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Baltimore MD or 28a-f show Baitimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Directo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21239 USA 6805 Barnett Road Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 Married Yes 2 X No Specify: white 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: é 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4 or 5+) Postal Service mail carrier 2 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beverly Aleathia Stewart Edwin William Melvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9510 Oakbranch Way; Baltimore, Maryland 21236 Kim Filer - cousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify 21. Signarre of Funeral Pervice Licens 22. Name and Address of Facility States Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and Medical Death a. Hyperthermia Complicating Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical attending physician or use as the burial -UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Day Fetal death 2 or use as past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown the bed 1 23e, Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>á</u> 1 Yes 2 No 3 Probably 4 V Unknown Breast carcinoma, Parkinson's Disease Completed 24a Was an 24b. Were autopsy findings available certificate has been prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 🗸 Other: Scene DOA ER/Outpatient 3 After this 1 🗸 Yes No 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death Certification: Subject exposed to hot ambient temperatures Aug 1, 2011 0000 hrs 1 Natural 1 Yes 2 V No Pending neral Director: Investigation 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 6805 Barnett Road, Baltimore, MD determined (Specify) Single Family Home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the ] one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified O.C.M.E. August 2, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D.

DHMH 17 Rev 1/2001 OCMF 2006

State Registra

31. Date filed (Month, Day, Year)

GOWE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 00:47 M alran eros July 30, 2011 Medical a Facility Name (if not institution, give street and number)
Baltimore Washington Medical Center 4c. County of Death
Anne Arundel Town, or Location of Death Glen Burnie **Examiner** 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 435–21–3933 **Funeral** 3/29/59 Year) Days Hours 1 🗶M 2 🗆 F Yrs Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland **Funeral Director** Anne Arundel Pasadena MD 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 8553 Skipjack Place 21122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 3 White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Rusiness Industry Elementary/Seconday (0-12) College (1-4 or 5+) Construction Electrician 12 2+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Mire Rita Nolan Bergeron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8553 Skipjack Place, Pasadena MD 21122 19a. Informant's Name/Relationship (Type, Print) Linda P. Bergeron/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2XXCremation 3 Removal from State Ardent Crematory 8/1/2011 Hanover MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Victor P.Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Provician/ acute nu disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** mary Sequentially list conditions Examine Due to (or as a consequence of): n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IE EEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No signed by the a ld be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed certificate has been si rector, page 2 should l 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA ည To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) Signature and title of certifier 38 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sles Burnie no 21061

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25100 State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 2. Date of Death Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and numb Examiner Maryland Greneral Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 240-40-183 (Month Day, 1 🗆 M 2 🖫 F 0 **Director** Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Completed by Funeral Director a.Himore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? USA 10 Ka Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Indust 15. Decedent's Education (Give kind of work done during most of working life DO NOT use retired) (Specify only highest grade completed) Elementary econday (0-12) College (1-4 or 5+) abover ather's Name (First, Be 🔿 liddle, Maiden Surnar or Town, State, Zip Code) 21239 20a. Method of Disposition ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) Yes 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 Probably 4 Unknown Records, 1 Yes 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 prior to completion of cause of death? After this certificate has funeral director, page 2 s 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type State

Registrar

25101

1-	For State Registrar
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Physiciar	1
/Medica	
Examine	ľ

**Funeral** Director

permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be notified at

Baltimore, Maryland 21215-0036 **Physician** /Medical

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Stat

	1 - State Registrar				Cer	tificate of I	Death			Reg. No.		
	1. Decedent's Name (First, Midd	dle, Last)							2. Date of De			3. Time of Death
an	Ross Josep	h Bred	chner						August	4 Day 20	011 <sup>Year</sup>	1:10 P.
al er	4a. Facility Name (If not institution	on, give stree	et and number)			4b. City, Town, or	r Location	of Death	- 0		unty of Death	1110 11
er						Catons		Baltimore				
	3 Dutton C 5. Social Security Number	6. Sex	7. Ag	e (In vrs.	last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Bir	f Birth 9. Birthplace (State of		
	075-32-4495	1 🔀 M	0 -	1	Yrs.	Months Days	Hours	Min.	June 2	, Year) 1940	Cour	neso <b>t</b> a
ŀ	Usual Residence of Decedent								-	, -,		
ı	10a. State 10b. County	у		10c. Cit	y, Town or Loc	cation					1	0d. Inside City Lim
ò	MD Balti	imore		C	atonsv	i 1 1 6						1 ☐ Yes 2 🛣
Director	10e. Street and Number	A.MOI C			TCOILD V.	10f. Zip Code				10a Citizen	of What Cour	ntry?
	3 Dutton Court	<del>-</del>					21228				SA	, .
Funeral												
Š	11. Marital Status	/	Was Decedent Armed Forces?		S. 13. V	vas Decedent of H f Yes, specify Cuba	iispanic Or an, Mexica	n, Puerto	ecity yes or No Rican, etc.)		Race - Americ Black, White,	
by F	1 ☐ Never Married 2 ☑ Ma		1 ∐Yes 2.2∰1 IfYes, Give	10	1	1 ☐ Yes 2 No Specify:					Specify: White	
8	3 Widowed 4 Divorce	-	Year or Dates:							101 101	15	1
Completed	15. Decede (Specify only high	nt's Educatio est grade coi	on <i>mpleted)</i>		(Give i	lent's Usual Occup kind of work done	during mos	st of work	ing	16b. Kind o	of Business/In	dustry
윤	Elementary/Secondary (0-12)	(	College (1-4or 5	+)		OO NOT use retired	,			Madda		
S .			JT		Physic	cian Anal				Medic		
Be	17. Father's Name (First, Middle								e (First, Middle,	Maiden Sur	rname)	
<u> </u>	Jules Brechner	<u> </u>					Ru	th Ci	naikin			
	19a. Informant's Name/Relation	ship (Type. F	Print)		19b. Mailin	g Address (Street	and Numb	er or Rui	al Route Numb	er, City or To	own, State, Zip	Code)
	Frances Mary H	Brouss	eau W	ife	3 Dut	ton Cour	t: Ca	atons	sville.	MD 21	228	
	20a. Method of Disposition			20b. P	lace of Dispos	sition (Name of natory or other place	i		Date		ion - City or To	own, State
	1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (		oval from State	1 .	-	Cremator		/6/2	011	Glen E	Burnie,	MD
-	21. Signature of Ameral Service		$\overline{}$	/		Name and Addre						
	21. Signature out griefa service		-//			Funeral 1	Home	of C	atonsvi	lle, ]	[nc.	
	· ace	£-	14	2		1630 Edm	ondso	n Av	enue; C	atons	ville.	
	23a. Part 1. Enter the diseas shock, or heart failure. Lis	r complications only one ca	ons that causec ause on each lir	the death ne.	n. Do not ente	er the mode of dyir	ng, such as	s cardiac	or respiratory a	rrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition		ATHRO			_ CARDIO						Onset and Death
	resulting in death)	a	Due to (or as						V	20		CUE
- 1												
ē	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	b. —	Due to (or as	นี จึงกลังบุง	rence of):							
Examiner	Cause (Disease or injury	<b>S</b>										
×	that initiated events c.  The properties of the control of the con											
9	d											
Medical	IF FEMALE:											
ä	23b. Was decedent pregnant in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)				23d. Date of delivery  Month Day Year					
Physiciar	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 □ Pregnant a 9 □ Unknown	t time of d	eath 5∟	Other (specify) _						
2									00 D:11			
<u>\$</u>	Part II. Other significant condit	ions contribu	uting to death b	ut not resi	ilting in the un	iderlying cause giv	en in Part	l.		1		he cause of death?
12									1 🗆	Yes 2.	√lo 3∏ Pro	bably 4 🗌 Unkno
									24a. Was		24b. Were auto	opsy findings availa
									auto	osy rmed? 2.X.No	death?	impletion of cause
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Completed									1 □ Yes	2 No		2 🗆 No
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lo Be Completed	examiner? 1 ☐ Yes 2 No  27. Manner of Death	Hospi 2	ital: 1  ☐ Inpatie 8a. Date of Inju (Month, Da	ry	ER/Outpatien 28b. Time of Injury	t 3 DOA Oth	er: 4 □ N ryat		h (Check only o	<i>nne)</i> dence 6 □	]Other <i>(Speci</i>	
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11-05761 Bridget Butler

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Physicia		egistrar . Decedent's Name (First, Middle,Last)						2. Date of Deat	h	3. Time of Death
ledical Examin	er	Bridget Rose Bu	ıtler					Month August 1,	Day Year 2011	1548 hrs
	4	la. Facility Name (if not institution, give	street and number)		- 1	•	ocation of Deat	h	4c. County of [	Death
		135 East Baltimore Street			Та	neytown			Carroll	
Funeral Director	5	6. Social Security Number 6. Sex 212-91-4250	7. Age (	In yrs. last bir	M	Under 1 Year onths Days 4 10	If Under 24Hr Hours Mir	n.		a. Birthplace (State or oreign Country Maryland
	_	Jsual Residence of Decedent					·!			
w any	1	0a. State 10b. County	10	Oc. City, Town	or Location					10d. Inside City Limits 1 X Yes 2 No
land f show	<u>ā</u> L	Maryland Carro	)11	_		Taney	town			
Mary 7.28m-	Director	0e. Street and Number			10f.	Zip Code		10	g. Citizen of What	Country?
h the		135 E. Baltimo				217			U.S.A	<i>A</i>
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f ahe fraumatic event, the Medical Examiner must be notified at once	E 1	Marital Status     Never Married 2 Married	12. Was Decedent Ev Armed Forces?	ver in U.S.			panic Origin? ( S Mexican, Puert	Specify Yes or No- o Rican, etc.)	14. Race - A White, e	merican Indian, Black, tc.
or dea	급		1 Yes 2 7	No.	1 Van	2 X No	anocifi:		Specify:	White
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ID 21215-0036 2 should be filed within 72 hours af and Mental Hygiene. 77 is marked other than "natural" matic event, the Medical Examin	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+				DO NOT use re			•
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	힐	0			neve	r worke	ed			n/a
5-00 ed wi Hygier other	ট্টা	7. Father's Name (First, Middle, Last)				18	8.Mother's Nam	e (First, Middle, N	laiden Surname)	
21 be fill mtal 1 rked	å	Bryan Roy Bu	tler, Jr.				_Je	nnifer M	ielke	
D 21	우 1	9a. Informant's Name/Relationship (Ty	pe, Print )	19	lb. Mailing Add	ress (Street	and Number or	Rural Route Num	ber, City or Town,	State, Zip Code)
y, MD 21 and 2 should fealth and Me tem 27 is ma traumatic ev	1	Bryan R. Butler Jr	./ father	1	135 E.	Baltim	ore St.		evtown, N	ID_21787
ore, slar of Hez Lite		20a. Method of Disposition  1 XBurial 2 Cremation 3	Removal from State		of Disposition tory or other pl		letery,	Date	20c. Location - Ci	ty or Town, State
Page Page ment or oth		4 Donation 5 Other Specify:		Middl					Middleb	
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumanti	2	1. Signature of Funeral Service Ligens	V 6						uneral Ho	
	1	23a. Firt I. Enter the disease, or simpli	M WU	e death Don					sor, MD 2	21776 Approximate Interval
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ated d	֟֟֟֞֟֟֟֡֟֟֟	events resulting in death) Last L d.								
execution and sian and sial - trans	Medical	X UNPENDED	AMENDED 23a,	,27,28a	a-f,per	me,g9	20 10-1	4-II sm		
60, ate be ex ohysician ne burial	ĕ⊨	F FEMALE:	23c. If yes, outcome	of pregnancy					23d. Date of de	livery
ox 68760, sath certificate be ex attending physician for use as the burial.	23 E   23	3b. Was decedent pregnant in the past 12 months?	1 Live birth  Pregnant at tin	no of doath	2 Fetal de		Ectopic pregn	ancy	Month	Day Year
Box 687  e death certific  the attending p ed for use as th	Physician/	1 Yes 2 ✓ No 9 Unknown	9 Unknown	ne or death	5 Other (	Specify)				
D. B.		Part II. Other significant conditions		out not resultin	ng in the under	lying cause giv	ven in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
P.O.	Ē							1 Yes	2 🗸 No 3	Probably 4 Unknown
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Vital ysician ysician directo	eg 2	examiner?	spital: 1 Inpatient	2 ER/0	Outpatient 3		34b		Residence 6	Other: Scene
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ath he fur	틸	1 Natural 5 Pending	fd 8-1-1	- 1	1 3:38 p	m 1 Ye	es 2 🗶 No	subject	accident	cally
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To the Hos within 24 h To the Fur	ᄝᆫ	2	On the basis of examinand manner stated.	nation and/or	investigation, i			at the time, date		
	∑ 2	29b. Signature and title of certifier	1/ 801	_		29c. License				(Month, Day, Year)
		Alle Bra.	self MIX	)		O.C.N	n.∟.		August 2, 20	11
	3	Name and address of person who co			900 M/ B	Itimore St	root Dalkies	ore MD 2422	3	
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Sta Registr		AUG 0 8 2011	A Level S	A.	ales					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25103 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month 3 August 10:58 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8408 20th Avenue Adelphi Prince George's . Social Security Number If Under 24 Hrs. 8. Date of Birth OCE. 28, 1920 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 F Months 207-03-0361 Pennsylvania 90 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Adelphi 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8408 20th Avenue USA 20783 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Ď should be filed within 72 hours after and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", White 3 X Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) State Office Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George V. MIller Ethel Bumgardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit, Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai 8408 20th Avenue Adelphi, MD Laura B. Morina 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lind Memorial Cem. 8-6-11 Lewistown, PA 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Hoenstine Funeral Home 75 Logan Street Lewistown, PA 17044 23a. Part I. Enter the disease, or complications that caused the second fine.

Anock, or heart failure. List only one cause on each line.

Bronchogeni Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Carcinoma Onget and Death Z Months Pnysician Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami led by the attending physician and detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 12 No death? this certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other 1 🗌 Yes 2x No S Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D08089 August 4, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Leibowitz, MD 11120 New Hampshire Ave Silver Spring, MD 20907

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

AUG 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-05706 State of Maryland / Department of Health and Mental Hygiene Charles Edward Buchanan 2011 Certificate of Death Reg. No. Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ 1059 hrs SR. CHARLES BUCHANAN July 30, 2011 EDWARD Medical Examiner 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Lanham **Doctor's Community Hospital** 8. Date of Birth (MM/DD/YYYY) 9. Birth place State NGTON If Under 24Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min Months Days Country) DC /30/1948 Director 62 Yrs. 1 X M 578-66-7486 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 No WASHINGTON t. Pages 1 and 2 should be filed within 72 hours after death with the Maryland tment of Health and Mental Hygiene. Trant: If item 27 is marked other than "natural", or items 23a or 28a-f sho r other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 1647 LANG PL NE 20002 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. uneral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 X Married 1 Never Married Yes Specify: BLACK ũ 1 Yes 2 X No specify: If Yes. Give Year 3 Widowed 4 Divorced ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE SUPERVISOR Baltimore, MD 21215-0036 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EDELL JOHNSON BUCHANAN VOYD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ NE WASHINGTON, DC 20002 1647 LANG PL., MARY BUCHANAN/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State BRENTWOOD, MD. 8/5/11 FT. LINCOLN CEM. 4 Donation 5 Other Specify 22. Name and Address of Facility CAPITOL MORTUARY 21. Signature of Funeral Arvice Licenses NE WASHINGTON DC20002 AVE MARYLAND Approximate Interva death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. Physician Between Onset and Death /Modital a. Hemopericardium Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Ruptured Aortic Dissection Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine c. Hypertensive Atherosclerotic Cardiovascular Disease cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED ☐ UNPENDED the attending physician ed for use as the burial -Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month 3b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy 1 Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. signed by t Division of Vital Records, P.O. 1 Yes 2 V No 3 Probably 4 Unknown Ś Diabetes Completed 24b. Were autopsy findings available 24a. Was an has been s prior to completion of cause of autopsy death? performed's 1 🗸 Yes 2 No ✓ Yes 2 No page certificate 26. Place of Death (Check only one) 25. Was case referred to medical Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🔲 DOA this 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day,Year) 27. Manner of Death After Certification: 1 Yes 2 No 1 V Natural Pending within 24 hours after death.

To the Funeral Director: the Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) <u>8</u> one) 29d. Date signed (Month, Day, Year)

Registrar

29b. Signature and title of certifier

Jack Titus MD.

30. Name and address of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

July 31, 2011

Ryshawn Cox 11-05592 unk unk

1-05592		Please Type or Print in Black Inde			
<del>nk un</del> k		State of Maryland / Depart	ment of Health and Men iicate of Death		2011 25105
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	Cate of Beath	2. Date of Deat	by No.  3. Time-pot Death
ledical Exami		Ryshawn Davion Cox		Month July 26, 20	Day lear
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location	of Death	4c. County of Death
-/		Johns Hopkins Hospital	Baltimore	Tank lane (n)	N/A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 1 Months Days Hours	1.00-	th (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland
Director		215-29-2823   1 <b>√</b> M 2□F   21	Yrs.	July 6,	1990 Country) Planty Land
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	wn or Location		10d. Inside City Limits
<b>E</b>	٠	MD N/A Balti	more		1 Yes 2 No
arylar Sa-f s	Director	10e. Street and Number	10f. Zip Code	11	Og. Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once.		4118 Elderon Avenue	21215	5	USA
n with	Funeral	11. Marital Stetus 12. Was Decedent Ever in U.S. Armed Forcas?	13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican		<ul> <li>14. Race - American Indian, Black, White, etc.</li> </ul>
r deat	된	1 Yes 2 No			Specify: Black
rs afte ural",	Ď	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16	a. Decedent's Usual Occupation (Give		16b. Kind of Business/Industry
5-0036 led within 72 hours a Hygiene. I other than "natura the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT		
036 ithin 7 ne.	힏	8th Grade	Unemployed		N/A
5-0 led w Hygie		17. Father's Name (First, Middle, Last)		r's Name (First, Middle, M	
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than ic event, the Medica	Be	Wendell R. Cox  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Nun	ette Anderso	
	욘	Lena M. Knox – Grandmother			re, Maryland 21215
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If Item 27 is injury or other traumet		20a. Method of Disposition 20b. Plac	ce of Disposition (Name of cemetery,	Date	20c. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		M+	natory or other place) Zion Cemetery	8/4/2011	Lansdowne, Maryland
litin nit. P artme ortan		4 Donation 5 Other Specify:  21. Signature of Funeral Service Lice/see	22. Name and Address of Facility		arris Funeral Home
E E E E		Gray Claris		town Road Ba	altimore, MD. 21215
Physician		23a Pert I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	not enter the mode of dying, such as o	cardiac or respiratory arre	Between Onset and
/Medical		Immediate Ceuse (Final disease or condition resulting in death)  a. Gunshot Wound of Back  Due to (or as a consequence of):			Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.			
	miner	if any, leading to immediate cause. Enter Underlying Cause			
16 -	Exam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
ox 68760, ath certificate be executed attending physician and or use as the burial - transit	calE	d. AMENDED #28a-b. Del	010 0 10 11		
D, be ex sician ourial		#3perME,G91	8,8/18/2011,WS	SM	
876 ificate ig phy s the t	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant 1 Live birth		c pregnancy	23d. Date of delivery  Month Day Year
X 6	icia	past 12 months?  4 Pregnant at time of death			
be death the att	Phys	g Onknown	Iting in the underlying cause given in Pa	and 1 220 Did to	bacco use contribute to the cause of death?
ires that the signed by it be detached	by	Part II. Other significant conditions contributing to death but not resu	ting in the underlying cause given in Pa		2 No 3 Probably 4 Unknown
ords, w require s been significations	Completed			24a. Was a	
COF law r has b e 2 sh	du				med? death?
Re ifficate or, pag		25. Was case referred to medical	26.Place of Death	(Check only one)	2 No 1 Yes 2 No
Vital Rec ysician: The his certificate director, page	o Be	examiner?		<del></del>	Residence 6 Other:
ing Ph After th funeral	$\vdash$	27. Manner of Death 28a. Date of Injury 28	Bb. Time of Injury 28c. Injury at Work	? 28d. Describe I Subject sho	now injury occurred
ion tendi	atio		206 hrs 1	No Subject sho	
ivis for Al after of Direc	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home	e, farm, street, factory, office building, et	or Town, S	Street and Number or Rural Route Number, City tate)
Dapital hours neral		4 Homicide determined (Specify) Local Street  29a, Certifier Control of Physician Physician Technology (Specify)			Belnord Avenue , Baltimore , MD
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burian	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/			
To with	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number		29d Date signed (Month, Day, Year)
		111 /10	O.C.M.E.		July 27, 2011
9		30. Name and address of person who completed cause of death (Item 23			
2			er 900 W. Baltimore Street,	Baltimore, MD 21	223
Si Regis	ate	31. Date filed (Month, Day, Year) 32. Registra's Signature	Kel		OCME
regis	and all	TIVE OF LUIT ASSOCIATION			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month U Physician/ Coley James Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** tal If Under 8. Date of Trth Security Number Age (In yrs. last birthday) Funeral 1 X M 2 D F Months Min 0.7 - 2Hours 59 215-60-5379 Director Usual Residence of Deceden show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland must be notified at Director 28a-f MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Funeral 23a 1119 Somerset Street 21202 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status of Health and Mental Hygiene.
item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner. Armed Forces? Black, White, etcAfrican 1 Never Married 2 Married Completed by 3 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: American 3 Widowed 4 Divorced JAMES 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Flementary/Seconday (0-12)
7th Grade Giant Food Market Laborer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mildred Elizabeth Coley James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -119a. Informant's Name/Relationship (Type, Print) enauon as Department of Health ar Important: If item 27 is any injury or other trau 1119 Somerset Street Baltimore, Maryland Diane M. Boulware-Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 🖫 Burial 2 🗆 Cremation 3 🖵 Removal from State cemetery, crematory or other place, 8-11-11 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 Gilmor Street BaltimoreMD. Ν. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ahen+ Immediate Cause (Final Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Bacteemia and Pneumonia Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Exami burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Li Fetal uses Pregnant at time of death sate has been signed by the atter page 2 should be detached for it in the past 12 months? Month 5 Other (specify) 9 Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 N or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours and To the Funeral L the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) M.D August 08,201 KES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE BALWAN SINA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

9. Birthplace (State or Foreign

Johnson

Approximate Interval Between Appt an Death

Day

scla

Year

10d. Inside City Limits

1 XYes 2 No

NA

:33AM

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 Day O4 Physician/ Lucaster 2011 Oppag 11:10 DM Medical Facility Name (if not institution, give street and number)

WAY WENT Location of Death Examiner 4c. County of Death Medico temore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** 213.54 Days Hours Min **Director** Usual Residence of Decedent Show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event,, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Pikesville 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Panacea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Verizor service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Matrie Kobert Benjamin Wilson 19a. Informant's Name/Relation bip (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Villie Panacea Coppagel Husband Court Pikesville Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Nation 2 Cremation 3 Removal from State 12/2011 Windsor Mill. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 89 vice Licens Vaughn · Greene Funcial Services dallstrum MD Hoad 2133 Kan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause Final Onset and Death Physician/ eronaru disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner provascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner 124 hours after death.

Funeral Director, After this certificate has been signed by the attending physician and hear in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 3 completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certil 29c. License numbe 29d. Date signed (Month, Day, Year) 04 08 72512 address of person who completed cause of death (Item 23a) (Type, Print) SSY Paw 22 South (Iveene Baltemore, MD South Creene Sheet

State Registrar 31. Date filed (Month, Day, Year)

AUG 0 8 2011

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kim Curtis anli Medical 4c. County of Death N/A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore Good Samaritan Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb 21,1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**XX**M 2 □ F Maryland 218-70-5641 52 959 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director N/ABaltimore 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21214 USA 3006 Pinewood Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 XMarried 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry State of Elementary/Seconday (0-12) College (1-4 or 5+) Maryland Correctional Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marie Benbow Eugene Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolljill Curtis/ Wife 3006 Pinewood Avenue Baltimore, MD 21214 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 8/10/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral electo 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arrhythmia disease or condition resulting in death) Due to (or as a conse nence of): Diabetes Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Heart Diseas Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 1 Yes 2 No 3 Probably 4 thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 PN 2 HNo 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 L No 은 1 Yes

physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t the been signed by has certificate After this s after death.

I Director: Aft
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**Funeral** 

Director

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or than "natural", or items 23a or the Medical Examiner must be

al Hygiene.

permit. Page 1 and 2 should be filed i Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event,

Physician

Medical

Examiner

Baltimore,

within 72 hours after death with the Maryland

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide work 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in the opening, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

ルマ State

Registrar

Certificate:

Medical

only one)

29b. Signature and title of certifier

athleen

athleen

nth, Day, Yea. **8 2011** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 7/2009

29c. License number

D0062689

august 3, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 11:43 P M BERNICE MORRISSEY COOPER August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ep. 20,1927 1 🗆 M 2 🔀 F Days Hours Min. Months Pennsylvania Director 83 212-24-6983 Usual Residence of Decedent an "natural", or items 23a or 28a-f show M dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 400 Chapel Court, #107 21793 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces' Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 11 clerical insurance underwriting Be 17. Father's Name (First, Middle, Last) th and Mental H 18. Mother's Name (First, Middle, Maiden Surname) ည Benjamin J. Morrissey Anne Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Mary Anne Hammond/daughter Sunhigh Ct. Thurmont, MD 21788 item 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Peter's Cem. 8/8/2011 Libertytown, MD 21. Signature of Inneral Service Lice 22. Name and Address of Facility Hartzler Funeral Home armores 11802 Liberty Rd. LIbertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Immediate Cause (Final DA PO eth E1515 Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed Yes 2 certificate 2 🗆 No 1 Tyes 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes Jnpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Investigation 24 hours after deat Funeral Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat le of certifie DOOBUU3 ress of person who completed cause of death (Item 23a) (Type, Print) TOPRUZ PREFERENCE. Mg 21702 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10 State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . Day 2011 Physician/ Daniels August 2, 7:41 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Oct. I2, 1917 Days Min 1 🔀 M 2 🗆 F Tennessee Yrs 93 410-09-7680 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland Director 1 ☐ Yes 2 🗓 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 9701 Medical Center Drive 20850 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Color Lab Tech Eastman Chemical Co. and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Belle Crawford William C. Daniels permit. Page 1 and 2 should Department of Health and Me Important; If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18709 Falling River Dr., Gaithersburg, MD Val C. Daniels (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 2 Cremation 3 Removal from State injury or 8-7-11 Maple Lawn Cemetery Jonesborough, TN Donation 5 Other (Specify) 22. Name and Address of Facility Dillow-Taylor Funeral Home 21. Signi ture of Puneral Service Lice e 418 West College Street, Jonesborough, TN 37659 un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final acute cardiae Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to lor as a consequence of cause. Enter Underlying signed by the attending physician and be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy performed? death? 1 ☐ Yes 2 🗓 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🖫 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred s after death. I Director: After t 1 🔀 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours To the Funeral I Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2011 H0051791 August 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, Manyland 20850 1901 Medical center Drive, Kile, DO

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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylan		artment of F tificate of D		Mental Hy	giene Reg. No. 2 (	11	251	12
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	eath w	Funeral	5000 Nannie H.  11. Marital Status	2. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of His	0019 spanic Origin? (Sp	pecify Yes or No-		<u>1tea</u> ce - Americ	State	S
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Baltimore,	permit. Pag Department Important: any injury o		21. Sign prof Funeral Service Censel	my fill	22	Name and Addres	s of Facility Ca	pitol :	Mortua	ry		0002
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires within 24 hours after death.  To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Completed						24a. Was autor perfo 1  Yes	rmed?		psy findings ava empletion of caus	
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	e Hospit 124 hour e Funera leted fille	Medical	(Check 2 Medical Examiner	an: To the best of my knowle : On the basis of examination Practioner: To the best of my	and/or investi	gation, in my opinio	n, death occurred a	at the time, date a	nd place, and du	ie to the ca	use(s) and manne	er stated.
	To the within comp	<	29b. Signature and title of certifier			29c. License	* "	440 10 11	29d. Date signe			
			30. Name and address of person who com	pleted cause of death (Item			0 //		1/2	3//		
	7		Ophnell Cumberba 31. Date filed (Month, Day, Year)			Hospita	al Driv	e Che	verly,	Md.	2078	5
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ AL WORST 201<sup>Y</sup>1<sup>ar</sup> 6:00 A M Georgetta U. Eggleston Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1055 W. Joppa Road #530 Towson 7. Age (In yrs. last birthday) 84 yrs If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** July 26 Hours 1 M 2 XF MarvTand 219-22-7551 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If time 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 XNo Marvland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 U.S.A. W. Joppa Road 1055 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Completed 3X Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည C. Yunker Catherine William Uhl. Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bahama, North Carolina 27503 Drake Eggleston / Son 12 Pearse Wynd Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 8/6/2011 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature of Funeral S 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or unjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Divísion of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an completed filled in by the funeral director, page 2 s autopsy performed To the Hospital or Attending Physician: The la within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No 1 🖂 Yes 2 X Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 A No 1 Tes 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Other (Specify, ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. priv one) 29c. License number completed cause of death (Item 23a) (Type, Print)

Registrar

State

6:00 Br

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Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August Mary 2011 5:00 AM Margaret Grayson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Hospital Center Carrol] Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 11,1918 1 🗆 M 2 🔀 F Months Hours West Virginia **Director** 214-07-0854 93 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🗌 Yes 2 🔀 No MD Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5030 Middleburg Rd. 21787 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🄀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) purchasing tool mfq. 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Eugene O'Leary Addie Shewbridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) V. David Grayson - son 4998 Middleburg Rd., Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation 8/8/2011 Sykesville, MD Six at ret of 5 Meral Service Licens 22. Name and Address of Facility Hartzler Funeral Home 310 Church St., New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death signed by the aid be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No 24 hours after death. Funeral Director: After this certificate has autopsy performed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examinar? Other: 2 No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 
Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No Langs Ry 8-03-2011 Accident

3 Suicide

4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Ro City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Taneytown Neme Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00059552 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOOK POOKE RO WESTMENSTER VOURISHAMOR 31. Date filed (Month, Day, Year) aistrar's Siana State

DHMH 17 Rev 7/2009

Registrar

AUG 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25115 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Florence Gillette 2011 Ann August 4:16 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice Dove House Carroll Westminster **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🎗 F Months Hours March 29, 1936 Maryland **Director** 212-34-5203 75 Usual Residence of Decedent show 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MD Carroll 1 X Yes 2 ☐ No New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2827 Carlisle Dr. 21776 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Force Black. White, etc. 1 Never Married 2 Married ☐ Yes 2 🔀 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give "natural", 3 X Widowed 4 ☐ Divorced White Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas Pinkney Cooper Anna M. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Easton - daughter 2437 Fox Chase Dr., Hanover, PA \_17331 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 8/6/2011 Sykesville, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Servi 310 Church St., New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Live Fetal 300.

Pregnant at time of death in the past 12 months 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page Yes 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🗜 🗲 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Sign

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Registrar

31. Date filed (Month, Day, Year)

343

ss of person who completed cause of death (Item 23a) (Type, Print)

aneng

Malealm dung Westminster MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 30 20 FT 20:53 Рм Baby Boy Green Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8, Date of Birth 7. Age (In yrs. last birthday, Social Security Number **Funeral** July 30, Year 2011  $1^{
m Min.}$ 1 X M 2 □ F Maryland Director INFANT Usual Residence of Decedent show 10c. City, Town or Location unk 10d. Inside City Limits 10a. State 10b. County unk 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 No DC 10e. Street and Number 10g. Citizen of What Country? 20002 Funeral 1218 Trinidad Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 X Never Married 2 Married ģ Specify: black Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates ntal Hygiene. ted other than "natura s event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) INFANT Page 1 and 2 should be filed within INFANT INFANT INFANT and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ည Michelle Dozier other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 1218 Trinidad Avenue; Washington, DC 20002 Michelle Dozier - mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board , pirector 21. Signature of Euneral Service Licensee Ronal Sylvan 655 W. Baltimore St; Baltimore, MD 21201 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician. Premature BIYTZ. disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** LENCRIE BITTA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami the burial-transit 430 Birth Weight Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical death certificate be as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No signed by the a d be detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page performed? Yes Q No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie D50649

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANIL KMAAAA AND

Mahayin

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#5perFH, G918, 8/12/2011, WS

State of Maryland / Department of Health and Mental Hygiene 25117 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 6:30A Aug. Hattie Hembrick 04 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Future Care Sandtown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 06-26-1 M 2 X F Days Hours 223-34-5725 **Director** Virginia 88 Usual Residence of Decedent ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director XX Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 21201 Franklin Street Apt. 622 W. USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ral", or iten Examiner i Black, White, etc.African Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. Specify: American "natural", 3 X Widowed 4 ☐ Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 11th Grade College (1-4 or 5+) Home maker Domestic NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Randolph Ben Hatcher 19a. Informant's Name/Relationship (Type, Print) ${\sf Daughter}$ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Eileen Hatcher-Connelly 4829 Midline Road Baltimore, MD. or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 Burial 2X Cremation 3 Removal from State 08-12-11 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. Gilmor Street Baltimore, MD. 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Corcorasculen Medical resulting in death) Due to (or as a consequence of): **Examiner** Hypesternsen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Poo Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 X Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 💢 No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Xi Nursing Home 5 Residence 6 Other (Specify) 2 🗙 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) NO. D 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. ENTAW ST Sinte 308 BALTIMORE MD 21201 A. HASHMI MD SHOAIB 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🤊 🕦 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician July 3 Day 2011 9:35 am /Medical City, Town, or Location of Death 4c. County of Death give street and number) **Examiner** rttumore N/A 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 10, (In yrs. last birthday **Funeral** Months Days Hours 215-12-1895 1 ■ M 2 F 92 Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits ā 1 Yes 2 No 28a-f sh notified MD N/A Directo Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or 21212 5220 York Road Apt. 7L USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items edical Examiner me Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten mortant: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examines and. I ☐ Yes 2 M No f Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Nurses Aide Keswick Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dora Harris Charles Banks, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Boatwright - Daughter 507 Campbell Lane Baltimore, Maryland 21212 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 MBurial 2 □ Cremation 3 □ Removal from State Pleasant Rest Cemetery 8/6/2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice vee 22. Name end Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 Approximate Interval Between Onset and Death 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition (anio Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ NO been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2∏ No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy fai 2 NO 1∐ Yes rena Hospital or Attending Physician; director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2016 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA To the Hospital or Attending Physimithin 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral director. 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury **₩**Natural 5 Pending investigation 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 69540 2011 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) MD words Ad suite Parkni 204

DHMH 17 Rev 1/2001

State Registrar

Elizabelh

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 20 11 Donald Bruce Johnston 1:38 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery Social Security Numbe 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F (Month, Day, Ohio Months Days Hours 1937 Director 74 219-34-8603 Jan. Usual Residence of Decedent 28a-f show 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Howard Woodbine 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? s 23a o Funeral 1825 Old Annapolis Rd. 21797 U.S.A. "natural", or items filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Armed Forces? Black, White, etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 Federal government managei Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental HIMportant; If item 27 is marked of any injury or other traumatic even ٩ Hollis Lee Johnston Molly Olivia Caffey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Johnston/ wife 1825 Old Annapolis Rd. Woodbine, MD 21797 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Chapel Cemetery 4 Donation 5 Other (Specify) 8/5/2011 nr. Libertytown, MD 21. Signifule of Femeral Service Licer 22. Name and Address of Facility Hartzler Funeral Home athania en P.O. Box 249 New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PULMONARY FIBROSIS Immediate Cause (Final ₹hysician/ MONTHS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) Exami sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 In No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🛂 No Yes the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No ျှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural Accident
Suicide 5 Pending work 1 🗌 Yes 2 🗌 No 24 hours after death Funeral Director: Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) make. JA 023630 AUGUST 2,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANK J. MAYO MD 16220 FREDER ECK READ R213 6ATHERS B-RB. MO

DHMH 17 Rev 7/2009

State Registrar FRANK J.

31. Date filed (Month, Day, Year)

26877

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:03 P Τ. Physician/ Julianne Johnson 5 Day 2011 Year Audast Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Baltimore Examiner Stella Maris Timonium Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F 200-16-2941 Months Hours Min Ma(Mont2,4Pay, Y1a923 Pennsylvania 88 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director HGUST 5, 1011 5:03,0M Mary land N/A Baltimore 1 Xyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 5523 Leith 21239 Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Koban Joseph Timko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16110 Baconsfield Lane Monkton, Maryland 21111 19a. Informant's Name/Relationship (Type, Print) Rosemarie Johnson/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 8/9/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Screens 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last use as the burial-trans Due to (or as a consequence of): signed by the attending physician d be detached for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an autopsy performed Yes 2 After this certificate has Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural Accident 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and 29d. Date signed (Month, Day, Year)

JOHNSON

DHMH 17 Rev 7/2009

State

Registrar

30. Name and a

AUG 0 8 2011

ALLEY ROTHUNIUM, MD

d cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BRANDT KAMKA **AUGUST** 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 803 DRUID PARK LAKE DRIVE BALTIMORE CITY N/A If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 215-84-3182 1 🛛 M 2 🗆 F Months 9757 7963 MARYLAND Director Usual Residence of Decedent 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d Inside City Limits be notified 28a-f MD N/A 1 Yes 2 □ No BALTIMORE CITY ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 803 DRUID PARK LAKE DRIVE 21217 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. Armed Forces?
1 ☐ Yes 2 🕅 No 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural" 3 Divorced 4 Divorced WHITE Year or Dates ed other than "natu event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry COLLECTION CO. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha MANAGER 4+ <u>Years</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ of Health and Ments fitem 27 is marked r other traumatic e GORDON KAMKA JOYCE ANDERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE CAVEY/MOTHER 241 VINE ROAD NEWTON, WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ٠ <del>ت</del> ا 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 8/8/2011 CATONSVILLE, MD 21. Signat /e of Funeral Service Licensee MO 1139 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cardialilmon disease or condition resulting in death) 10 MITUR Medical Due to (or as a consequence of): Examiner arter swe Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a consequence of). Exami within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The 124 hours after death. Funeral Director: After this certificate h performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5 Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 ☑ No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending work?
1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signature and title of certifier 29c, License number 38675 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST PAUL PL # YOU MESHULAN BALTIMONE MO 21202

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed Month

Day, Year)

0 8 2011

AUG

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	aryland /				and M	-		nii	2512	2	
			Registrar  1. Decedent's Name (First, Middle, Last	*)		Cen	tificate of E	Jeath		2. Date of Dea	Reg. No.	.011	3. Time of Deat		
	Physicia Medic		YVONNE LYDE							Month AUGUST	Day 2	Year 20/1		4M	
#** **********	Examir		4a. Facility Name (if not institution, give s UNIVERSITY OF MARYU		CENTER	2	4b. City, Town, or BALTING		of Death		4c. (	County of Dea			
	Funeral Director		212 30 1003	x □ M 2 <b>X</b> □ F 7. Ago	e (In yrs. last bii 71	rthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt	Year)	_ Co	thplace (State or Fore untry) ryland	eign	
	and show lat	b	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Loc	ation			,	10d. Inside City Limits				
	Maryl: 28a-f otifiec	Director	MD N/A	1			Balti	more					1 <b>X</b> Yes 2 □	] No	
	with the is 23a or nust be n	10e. Street and Number 431 9 Shamrock Avenue 21206  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14.)									en of What Country? USA				
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	11. Marital Status  1	12. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.		If	/as Decedent of Hi Yes, specify Cubar	n, Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit pecify: B			
15-0	72 hour 1 "natu ledical	Completed	15. Decedent's Ed (Specify only highest grad		16	(Give ki	ent's Usual Occupa ind of work done d		of workin	ng	16b. Kin	d of Business	Industry		
212	within giene. er thar , the M	Con	12th Grade	College (1-4 or 5	i+)		NOT use retired) loor Te	chni	cian	1		Hos	pital		
/land	d be filed Mental Hy, arked oth	To Be	17. Father's Name (First, Middle, Last) Broadie Lyde							(First, Middle, I		ırname)	~		
Baltimore, Maryland 21215-0036	id 2 shoul salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type Earl Ford/ Gran		19 <b>4</b>	b. Mailing	Address (Street a	nd Numbe	r or Rural Venu	Route Number 1e Bal	; City or Ti timo	own, State, Zi	D 21206		
more	Page 1 an nent of He int: If iten iny or oth		20a. Method of Disposition  1 🐰 Burial 2 🗆 Cremation 3 🗆 4 🗆 Donation 5 🗀 Other (Specify,		20b. Place of cemete	of Dispos ery, crema	ition (Name of atory or other place Star C	8/9 emet	/11¤ erv	ate		ation - City or	Town, State		
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service License	arre)	1	22.		s of Facility	Cha		Harr	is Fu	neral Ho	me	
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on	ications that caused e cause on each line	the death. Do	not enter	the mode of dying	g, such as o	cardiac or	respiratory arr	est,		Approximate Interval Between		
	Physician Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	DIAL IN	of):	tlan				-		Onset and Death		
	Examiner	er	Sequentially list conditions,	b.	i consequence										
8	outed nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	C	Consequence	01).									
) <sup>7</sup>	icate be executed physician and sthe burial-transit	edical E	resulting in death) Last	Due to (or as a	consequence	of):									
8760	ificate ig phys as the	Medi	IF FEMALE:	J							_				
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	3c. If yes, outcome of 1 Live Birth 1 4 Pregnant at 9 Live Windows	2 Fetal deat	th 3 🗆 5 🗆	Ectopic pregnancy Other (specify)	/			23	3d. Date of de Month	livery Day Year		
P.0	s that th gned by e detac	by Ph	Part II. Other significant conditions cor	ntributing to death bu	ut not resulting	in the un	derlying cause give	en in Part I.	•	23e. Did to	bacco use	e contribute to	the cause of death?		
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Records, P.O.	. The law r cate has b page 2 sl	Completed								24a. Was a autop perfor 1 \(\sum \) Yes	sy	prior to death?	topsy findings availat completion of cause of 2	ole of	
Vita	s <b>ician</b> : certific	Be	25. Was case referred to medical examiner?  1  Yes  No	ospital:			Othe	ce of Deatl							
n of V	ding Phys h. After this funeral di	ate: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of injur (Month, Day,	y 28b.	utpatient Time of injury	28c. Injury work?	4 <u> </u>	28	ne 5 Reside 8d. Describe ho			ify)		
Division of	l or Atteno after deat Director: In by the	Certificate:	2  ☐ Accident	28e. Place of Injurbuilding, etc.		arm, stree		Yes 2 🗌	-	8f. Location (Si City or Town		Number or Ru	ral Route Number,		
_	Hospita 24 hours Funeral eted filled	edical	29a. Certifier (Check 2 Medical Examin	er: On the basis of ex	amination and/	or investic	ation, in my opinior	death occ	curred at the	he time date an	d place a	nd due to the	rause(s) and manner s	stated.	
	To the within To the comp.	Σ	only one) 3	Tacuoner, to the t	Jest of HIV KNOW	vieuge, de	29c. License		and place			and manner as signed (Montl			
			Dant Aff	-M.D			P2558	2			8/2	2611			
	3		30. Name and address of person who co				,				-				
	Stat	e	31. DAUG (0'8' 2011")	32. Registr	's Signature	MEDI	CAL CENTER	22 50	ovim 6	REENE!	ST, But	LTIMERE	MD 2/2/0		
	Registra	ır	100 0 0 2011 /CE	, J.	1										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 10: 14 PM BETTY 08 04 KAY LUCKEY 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL SAMARITAN BALTIMORE 400 D 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 □ 📉 (anlina 212-78-605 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 No 2 No Director IM 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe 212 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | Zelo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 ☐ 10 Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) æ marked other Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee auc Wances n. Wallace 23a. Part 1. Enter the interest, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart this are. List only one cause on each line. Approximate Interval Between Onset and Death Physician MYPOXIA disease or condition resulting in death) /Medical Failure Due to (or as a consequence of): SLEEP APNEA / RESPIRATORY Examiner months b. OBSTRUCTIVE Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit SEPSIS resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an disorder autopsy certificate 2 **N**o 2 **N**0 Rocterem 1 ☐Yes 1 □ Yes multiple 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \sum Nursing Home 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) the funeral 27. Manner of Death 1 ☑ Natural 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 ☐ Homicide Hospital e Funeral I to critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continue of the death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and due to the cause(s) 29a, Certifier and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

4

State Registrar 5601 LOCH A.Day, Year) AUG ( 8 2011 /

RAVEN SLVD,
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE

RES

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2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	ı	For State Registrar	State of Maryland		artment of F tificate of E			ene 201	25124			
Physicia Medio		Decedent's Name (First, Middle, Late     DAVID	LEONARD		LIPSI	TZ	2. Date of Death August		3. Time of Death			
Examir		4a. Facility Name (if not institution, give Maryland Gene	val HOSpital	1	Ab City, Town, or Baltin	Location of Death	ty	4c. County of De	ath			
Funeral Director		5. Social Security Number 6. S 214 – 56 – 3254	ex 7. Age (In yrs. lat		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 8 – 2 2 – 19	9. B	irthplace (State or Foreign			
/land f show ed at	tor	Usual Residence of Decedent  10a. State  10b. County		Town or Loc		DUDG	-		10d. Inside City Limits			
the Mary or 28a- oe notifie	l Direc	10e. Street and Number	IMORE		RASPE 10f. Zip Code		1	0g. Citizen of What 0	1 Yes X No			
eath with ems 23a er must b	Funeral Director	3805 GLENMORE  11. Marital Status	12. Was Decedent Ever in U.S.		Vas Decedent of His	21206	ecify Yes or No-		S.A.			
ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	2	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 XYes 2 No If Yes, Give 1967 Year or Dates.	If	Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, White, etc. Specify: WHITE				
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed	15. Decedent's Elementary/Seconday (0-12)	ducation ade completed) College (1-4 or 5+)	(Give k	sedent's Usual Occupation e kind of work done during most of working DO NOT use retired)			16b. Kind of Business Industry				
d 21%	Be Co	1 2	2	CO	MPUTER	BALTO. S						
Aarylan should be file and Mental is marked or raumatic ever	욘	Samuel  19a. Informant's Name/Relationship (7)		sitz		Winif	red	A. (	Varina )			
e, Ma and 2 sho Health an tem 27 is in		LINDA A LIPSIT	Z/WIFE			RE AVE	BALTIM	Oity or Town, State, 2 IORE, MD	<sup>Zip Code</sup> 21 206			
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State ce	metery, crem	sition (Name of atory or other place CEMATORY	e) :	Date 2 -2011	CATONSV	or Town, State			
Baltimo permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licens				s of FacilityCVA		DALE FU	NERAL HOME D 21237			
∼Physician/		23a. Part 1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final	plications that caused the death.	Do not ente	1				Approximate Interval Between Onset and Death			
Medical Examiner		disease or condition resulting in death)	a. Due to (or as a conseque	ence of):	4550cla		HUMON					
sit sd	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  b. Due to (or as a consequence of):  Dance of the conditions of										
f <b>bU</b> cate be executed physician and the burlal-transit	al Exal	that initiated events resulting in death) Last	c. Du (or as a conseque	nce of):	4 /u//	WE						
<b>b8 / bU</b> sertificate booking physic ise as the b	Medical	IF FEMALE:	d									
DIVISION OF VITAL RECORDS, F.O. BOX 68 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	23c. If yes, outcome of pregnand 1	death 3 🔲	Ectopic pregnancy Other (specify)	у		23d. Date of delivery Month Day Year				
dS, F.O.	þ	Part II. Other significant conditions co		ting in the ur	nderlying cause give	en in Part I.	23e. Did toba	_/	to the cause of death?  Probably 4 □ Unknown			
Hecords, The law requires ate has been sig	Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of es 2 \( \sum \text{No} \)			
VITAI ysician: is certific director,		25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	R/Qutpatient	0	r:	( only one)	ice 6 Other (Spe	cifu)			
OVISION OF or Attending Phatter death. Director: After the in by the funeral		27. Manner of Death  1 In Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	8b. Time of injury	28c. Injury work?	at	28d. Describe how		,			
I or Atte	Certificate:	3 Suicide 6 Could not by 4 Homicide determined		e, farm, stree	et, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,			
he Hospita in 24 hours he Funeral pleted fille	Medical	(Check 2 Medical Exami	sician: To the best of my knowled ner: On the basis of examination a se Practioner: To the best of my k	and/or investig	gation, in my opinior	n, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.			
To t with To tl		29b. Signature and title of certifier	140		29c. License			d. Date signed (Mon				
		30. Name and address of person who c	ompleted cause of death (Item 2	3a) (Type, Pr	int)	Gener	al the	prial				
Stat Registra	_	31. Date filed (Month, Day, Year) AUG 0 8 201	37. Registrar's Signat	KI								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Mary State Registrar		tificate of De			eg. No.	25125
	Physicia		1. Decedent's Name (First, Middle, Last)  Edwin L. Lewis				2. Date of Deat Month	Day Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L	ocation of Death	08	4c. County of Deat	th •
	/		TENINSULA AQUINAL Mulical  5. Social Security Number 6. Sex 7. Age (In	CONTRA	If Under 1 Year	16136474 If Under 24 Hrs.	8. Date of Birth	Wicom	
	Funeral Director		212-26-2940 1 → XM 2 □ F	yrs, last birthday) 81 Yrs.		Hours Min.	1/6/193	0 Mar	thplace (State or Foreign untry) y land
	land show dat	tor	Usual Residence of Decedent  10a. State 10b. County 10c	c. City, Town or Loc	eation				10d. Inside City Limits
	e Mary r 28a-1 notifie	Director	Delaware Sussex  10e. Street and Number	Selbyvill				0	1 Tes 2x No
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral [	37096 Blue Bill Drive		10f. Zip Code 19975			U.S.A.	ountry?
	death		11. Marital Status  12. Was Decedent Ever in Armed Forces?	in U.S. 13. W	Vas Decedent of Hisp Yes, specify Cuban,	oanic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
036	rs after rral", o Exam	ed by	1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates.	1	☐ Yes 2 🔀 No	Specify:		Specify: Wh	ite
15-0	72 hour	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupati		ng	16b. Kind of Business	Industry
21215-0036	within 'giene. er thar t, the M		Elementary/Seconday (0-12) College (1-4 or 5+)		onoruse retired) trical Eng	jineer		Engineeri	ng
and	e filed ntal Hyy ed oth event	To Be	17. Father's Name (First, Middle, Last)  Milton I. Lewis			18. Mother's Name		faiden Surname)	
ary	should be file n and Mental I 7 is marked o ranmatic eve	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin				City or Town, State, Zi	p Code)
Σ̈́	and 2 st Health a tem 27 is		Doris M. Lewis / Wife	37096	5 Blue Bil		Selbyv	ille, DE_1	9975
nore	Page 1 and ment of Hea <b>ant: If item</b> ury or other		1 N Burial 2 Cremation 3 Removal from State	20b. Place of Dispos cemetery, crem Dulanev	sition (Name of natory or other place) Valley Men		I	20c. Location - City or Timonium,	
Baltimore, Maryland	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	22.	. Name and Address	of Facility Ruc	k Towso	n Funeral	Home, Inc.
			23a. Part 1. Enter the disease, or complications that caused the		050 York R	-		ryland 212	04 Approximate
~	Physician/	8	shock, or heart failure. List only one cause on each line.		591			 5	Interval Between Onset and Death
	Medical Examiner				t fainre				
		er	Sequentially list conditions, b. Due to for as a condition by the distribution by the sequentially list conditions, but to for as a condition by the sequentially list conditions, but the sequentially list conditions are sequentially list conditions.	menia					
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjiury that initiated events  c						
_	cate be executed physician and s the burial-transit	cal E	resulting in death) Last Due to (or as a con	nsequence of):					
3760		Medical	JF FEMALE:						
0 X C	ath certifica attending p	ian/I	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
P.O. Box 68	the dea by the a	Physician/N	1 Yes 2 No 4 Pregnant at time 9 Unknown 9 Unknown	e or death 5 C	Other (specify)		1		
% D.	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause give	n in Part I.		oacco use contribute to es 2 ☐ No 3 ☐ F	o the cause of death? Probably 4 Unknown
Division of Vital Records,	w requi	Completed					24a. Was a		utopsy findings available completion of cause of
Rec	The lar	Com					autops perfori 1  Yes	med? death?	s 2 🗆 No
/ita	Physician: 1 r this certifice ral director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital:  1 ☐ Inpatient	2 ER/Outpatien	Other	e of Death (Check		ence 6 Other (Spec	2:54
of	ng Phy fter this ineral d	te: To	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  1 ☑ Natural 5 ☐ Pending	28b. Time of	28c. Injury a			w injury occurred	sny)
sion	Attendi death. ctor: A y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	At home, farm, stre	M 1 □ Ye	es 2 🗆 No	28f. Location /St	reet and Number or Ru	ural Route Number,
DIX	ital or / irs after al Dire led in b	al Cei	4 Homicide determined 286. Place of Injury - building, etc. (Sc	pecify)			City or Town		
	To the Hospital o within 24 hours af To the Funeral Di completed filled in	Medical	29a. Certifier (Check only one) 1 Mertifying Physician: To the best of my kertifying Physician: To the best of my kertifying Nurse Practioner: To the best of my kertifying Physician: To the best of my kertifying	ination and/or invest	igation, in my opinion,	, death occurred at	the time, date an	d place, and due to the	cause(s) and manner stated.
	To th within To th	~	29b. Signature and title of certifier		29c. License r			9d. Date signed (Mont	
	,		30. Name and address of person who completed cause of death	(Item 23a) (Type, P	rint)	268122		08-0 ND 318	3-11
( )	V		Raza Afzal, m. 100 31. Date filed (Month, Day, Year) 32. Date filed (Month, Day, Year)	E. Carro	1154.	Salisho	cry, 1	ND 318	01
	Star Registra		AUG 0 8 2011	d. de	are				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Dora Dean Murray 0:48 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Union Memorial Hospital Baltimore Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 6. Sex 7. Age (In vrs. last birthday) 1 🗆 M 2 🗙 Hours 212-26-4993 Director 82 28,1929 Virginia Feb. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1020 E. 33rd St. Apt. 21218 USA ral", or items? Examiner mus 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces Black, White, etc à 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: Completed Specify: Black 3 X Widowed 4 ☐ Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Forest Haven Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home Nursing Assistant 8th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Jones Frances Harmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Irene Hicks/ Daughter 224 Chestnut St. Dundalk, MD 21222 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Cedar Hill Cemetery 8/12/11 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Deat Physician/ Metastatic months disease or condition Medical resulting in death) **Examiner** stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown signed by the a 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Funeral Director: After this certificate has autopsy page performed 2 🗌 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 1 🗌 Yes 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Spec 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation M the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by after determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 4:40RM Morris T. Moten 08- 02-2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3412 Kelox Road Baltimore Gwynn Oak If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Sex 1X M 2 □ F 8. Date of Birth Funeral Social Security Num. 5**79–76–**35**1**2 5/2/1958 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location event, the Medical Examiner must be notified at Director Baltimore Gwynn Oak 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3412 Kelox Road 21207 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? ò þ 1 Never Married 2 X Married Maryland 21215-0036 Specify African-American 1 Yes 2X No Specify. If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Car Inspector Koon's Tyson Toyota 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Taylor Gloria Moten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra Cecelia J. Moten/Wife 3412 Kelox Road Gwynn Oak, Maryland 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ㅎ 1 X Burial 2 Cremation 3 Removal from State Arbutus Memorial Park 8/9/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co 9200 Liberty Road Randalls town, Maryland 21133 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancel Physicians disease or condition resulting in death) Medical Examiner Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on Exami physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph d for use as th IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Month 4 Pregnant at time of death 9 Unknown the g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director; I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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State

31. Date filed (Month, Day, Year)

AUG 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Raymond Earl McGeever Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Westminster Dove House of Carroll Hospice If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number Funeral Days Hours 1 X M 2 . F 66 **Director** 196-34-8872 Usual Residence of Decedent 28a-f shov th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Washington Hagerstown MD 10e. Street and Numbe 10f. Zip Code Funeral 21742 11906 Wesley Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Be 17. Father's Name (First, Middle, Last) should be file and Mental H ပ Raymond Earl McGeever permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 635 Uniontown Road, Westminster, MD 21158 Sean McGeever/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grandview Cemetery Signature of Funeral Service Licensee J. Kein Stile 313 Talbott Ave., Laurel, MD 20707 M01053 23a. 🚧 1. Enter the disease, or complications that caused the definition of the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequente of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence or): physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician certificate be Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Į Pregnant at time of death To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached f Unknown P.0. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, Completed 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital 2 🖸 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of Certificate: 28c. Injury at Director: After 1 Natural 2 Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined hours after the Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 입 29b. Signatu of person who completed cause of death (Item 23a) (Type, Print) STONERAUE

Carroll 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Oct. 3, 1944 PA 10d. Inside City Limits 1x Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business Industry Aerospace 18. Mother's Name (First, Middle, Maiden Surname) Shirley Murphy 20c. Location - City or Town, State August Johnstown, PA 2011 22. Name and Address of Facility Donaldson Funeral Home, P.A. Onset and Death 23d. Date of delivery Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 2 🗹 No 1 🗌 Yes Yes 6 Other (Specify) 5 Residence 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) WESTMINSTER, MD 21/57

2. Date of Death

August

3. Time of Death

аМ

7:50

2011

4c. County of Death

State

31. Date filed (Month, Day, Year)

AUG 0 8 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G918 8/16/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2011 Physician/ 6:00 A M Wilbur Oscar Miller August 6 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Parkville 8800 Walther Blvd # 2308 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In vrs. last hirthday) **Funeral** 1 **X** M 2  $\square$  F Davs Hours Mary land 212-03-8863 1071671915 95 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified Parkville 1 ☐ Yes 2 🔀 No Baltimore Marvland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 Funeral 8800 Walther Blvd # 2308 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. 3 X Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business Industry
United States 15. Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Government Army Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Grace Emma Kirk Wilbur Oscar Miller, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
123 Tulip Poplar Ct. Aiken, South Carolina 29803 Department of Health and Important: If item 27 is r. any injury or other trauma once. 19a. Informant's Name/Relationship (Type, Print) Mark R. Miller / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/31/11 1 X Burial 2 Cremation 3 Removal from State Arlington, Virginia Arlington Nat'l Cem. 4 Donation 5 Other (Specify) Signature of Funeral Service accesse 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Cerebrovascular disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death ed by the a detached i 9 Unknown 9 Unknown s been signed by the should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown stenosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) director, Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \)Residence 6 \(\sum \) Other (Specify) 2 No Hospital 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work? 1 Natural 5 Pending Accident Investigation Sulcide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gettiying Nurse Practioner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 1758646 mone 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boo levourd Monics 6800 wa

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 8 2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 25 | 30 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certific	cate of	Death			Reg	No.		
Physici		1. Decedent's Name (First, Middle						- 1	Date of Death Month	ay Yea	ar	3. Time of Death
ledical Exami	ner	Henry Owens, J				b Oibs Tassa	-1		July 29, 201		-f Do -th	0845 hrs
		4a. Facility Name (if not institution 3700 Greenspring Ave			4	b. City, Town, or Baltimore	r Location o				N/A	
Funeral		Social Security Number		n yrs. last bi	rthday)	If Under 1 Yea					9. Birtl Foreign	hplace (State or
Director		213-54-3258	1 M 2 F	61	Yrs.	Worturs	ys Hours	(Alli.)	Jan. 1,	1950	Cou	Maryland
any		Usual Residence of Decedent  10a. State 10b. County	110	c. City, Towr	or Location	n .						10d. Inside City Limits
. €	or	MD ISSUE SOUTHLY		Baltim		,,,,						1 Yes 2 No
Maryi 28a-1	Director	10e. Street and Number		10f. Zip Code						. Citizen of Wh	try?	
th the Maryland 23a or 28a-f sho notified at once	Ē	3700 Greenspri	ng Avenue Apt	. 810			2121	1		Ţ	JSA	
th with	era	11. Marital Status  1 Never Married 2 Ma	12, Was Decedent Ev	er in U.S.		Decedent of Hi				14. Race White		can Indian, Black,
er dea	Funeral		1 Yes 2 V	No		Yes 2 V No				Specify:		~k
urs aft tural"	d by	15. Decedent's Education (Spec	or Dates:	ted) 16a.		's Usua! Occupa		kind of work	done 1	6b. Kind of Bu		
72 hou	etec	Elementary/Secondary (0-12)	College (1-4 or 5+)		during mo	st of working life	DO NOT	use retired	)			
036 Atthin one.	Completed	12th Grade			Mor	ving and	] Hau]	ling		Self	Ĩ–Emj	ployed
5-0 iled w Hygic		17. Father's Name (First, Middle,				•		•	rst, Middle, Ma	den Surname)	)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	Henry Owens, S: 19a. Informant's Name/Relationsh		110	h Mailing	Address (Stree			Lliams	or City of Town	n Stata	Zin Codo)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand Mental Hygiers in the Maryland Important. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	٩	Joyce Owens - 8				Park Hei						
G, P. I and Health		20a. Method of Disposition			of Disposit	ion (Name of ce	metery,	D	ate 2	0c. Location -	ocation - City or Town, State	
Baltimore, permit. Pages 1 ar Department of Hee important: If ite		1 Burial 2 Cremation 4 Donation 5 Other Spe	3 Removal from State			rematory	7	8/4/2	20111	Baltimo	ore,	Maryland
Balti permit. Departm Imports injury o		21. Signature of Funeral Service			22. Na	ame and Address	s of Facility	' Chat	man-Ha:	rris Fu	ner:	al Home
		Kroy War	ri			10 Reist						
Physician /Medical		23a. Part I. Enter the disease, or of failure. List only one cause of	on each line.					ardiac or re	spiratory arrest	, shock, or hea	art	Approximate Interval Between Onset and
Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):											Death	
		Sequentially list conditions,	b	-								
	iner	if any, leading to immediate	Due to (or as a consequent	ence of):								
. 4.4	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):								
760, Cate be executed physician and the burial - transit		d amended										*
760, cate be exc physician he burial -	/Medical	UNPENDED										
		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of			il death 3	Ectopic	pregnancy		23d. Date of Month	•	ay Year
ox 687 eath certifi	Physician	past 12 months?	4 Pregnant at time			er (Specify)						
BOX he death c the atten hed for us	چ	1 Yes 2 No 9 Unkr	9 Unknown						loo- pilis	4-1	h 4 4 - 4	he cause of death?
Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending page 2 should be denothed for use as	by	Part II. Other significant condition	ons contributing to death bu	t not resultin	ig in the un	ideriying cause (	given in Pai	π Ι.			_	ably 4 V Unknown
rds, require been sig	Completed								24a. Was an			opsy findings available
COL law r has b	흴								autopsy performe	d? d	rior to co leath?	empletion of cause of
		OF 144				00.01		01 - 11	1 ✓ Yes 2	No 1	✓ Yes	2 No
Vital ysician his cert directo	B	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 FR/O	utpatient	printer.	Other -	Check only Nursing H		sidence 6	Other	Scene
n of Vital Records, ting Physician: The law requir After this certificate has been si funeral director, page 2 should b	임	1 Yes 2 No 27. Manner of Death	28a. Date of Injury		Time of Inj		ry at Work		d. Describe hov			-
E ig ii g	톓	1 Natural 5 Pendi				1 🗆 🗅	Yes 2	No				
Division tal or Attendi rs after death. al Director:	ifica		igation 28e. Place of Injury	- At home, fa	arm, street,	factory, office b	ouilding, etc	. 28f			r or Rura	al Route Number, City
To be the control of									or Town, Stat	<del>-</del> ,		
의 등 보고 아니네이 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 ✔ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.												
To witi	Me	29b. Signature and title of certifier	City manifel stated.			29c. Licens	e number		2	9d. Date signe	d (Mont	th, Day, Year)
\		12 la.	- Polon	_		O.C.1	M.E.		-	luly 29, 20	11	
7	İ	30. Name and address of person v			incr ^	00 104 10-14:-	nore Ct	oot Patt	imore ND	11222		
	ate	Patricia Aronica-Pollak  31. Date filed (Month, Day Year)	MD. Assistant Med		mier 9		noie Sife	cei, Bail	more, MD	1223		
Regist	rar	31. Date filed (Month, Day, Year) AUG 0 8 2011	Cenus S.		Nel.							

DHMH 17 Rev 1/2001 OCME 2006 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Marylar		artment of H <i>tificate of D</i>			giene Reg. N. 0		25131
	Physicia		1. Decedent's Name (First, Middle, Last	Russell E	lwood I	Palmer. S	r	2. Date of Dea Month Augus t		Year 11	3. Time of Death 11:00 AM
	Medic Examin	_	4a. Facility Name (if not institution, give		IWOOQ I		Location of Death	magas	4c. County		1 11.00 11
	,	•	Laurel Regional	Hospital		Laurel			Prin	ice G	eorge
	Funeral Director		5. Social Security Number 6. Se 218-34-6350	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat July 2	th 9, Year) 8, 1939		place (State or Foreign atry) Virginia
			Usual Residence of Decedent								
	yland f sho ed at	Director	10a. State 10b. County		ty, Town or Loc					1	10d. Inside City Limits
	e Mar r 28a notifi	ji.	MD Prince  10e. Street and Number	George Be	ltsvill	10f. Zip Code			10 0''' 5	14/1 1 0 1	1 X Yes 2 No
	/ith th		4825 Lexington A	venue		20705			10g. Citizen of U.S.A.		nuy?
	ems	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-		ce - Americ	can Indian,
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 2a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		Yes, specify Cubar		Rican, etc.)	Blan Specify	ck, White, ' <sup>:</sup> Whi	
Maryland 21215-0036	nours latura ical E	Completed	15. Decedent's Ed	Year or Dates.	16a. Deced	ent's Usual Occupa	ation	-	16b. Kind of B		
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2	withii glene ler th		6	College (1 4 of or)	Heavy	Equipme	nt Operat	or	Constr	ucti	on
nd	tal Hy d oth	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Surnam	e)	
<u>Ş</u>	uld be I Men narke	-	Harry Boston Pal		_		Vera Ell				
ă ⊠	I 2 sho Ith and 27 is r r traur	- 3	19a. Informant's Name/Relationship (Ty		AP.	g Address (Street a					
ď.	Heal Heal tem S		Shirley A. Palme 20a. Method of Disposition	20b.	Place of Dispo	Lexingto: sition (Name of	ŀ	Date	20c, Location		
JOE L	Page 1 anent of Page 1 ant of Page 1 and of Page 1 and or		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			natory or other place		8. 11	Odento:	n. Ma	rvland
Baltimore,	permit. Page 1:8 Department of H Important: If ite any injury or ot		21. Sign store of Funeral Service Listers			Name and Addres				,	12 / 201101
m	De D		Kellitt Co	M00	//3 3	313 Talbo	tt Ave. I	<u>aurel,</u>	<u>Marylar</u>	ıd 20'	707-4389
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the dear e cause on each line.	th. Do not ente	r the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician/	0 4	Immediate Cause (Final disease or condition	a Cancer of	Lung					- 11	Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conseq							į
		er	Sequentially list conditions, if any, leading to immediate	b. Cardio-res		y arrest				-	
	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or linjury		,						
	execu an and ial-tra	Ex	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
9	cate be executed physician and s the burial-transit	edical		d						$\rightarrow$	
387	artifica ding p	/Me	IF FEMALE:	23c. If yes, outcome of pregna	anev						
X	ath ce attenc for us	cian	in the past 12 months?	1 Live Birth 2 Fet 4 Pregnant at time of	al death 3 🛚	Ectopic pregnanc Other (specify)	у			ate of deliv onth	/ery Day Year
P.O. Box 687	he de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	304.1						
P.0	that t ned b e deta	y P	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use con	tribute to t	he cause of death?
ds,	quires en sig vuld b	ted	COPD					1 🗆	Yes 2 No	3 $\square$ Pro	bably 4 🛭 Unknown
Sor	aw ree as be 2 sho	Completed by						24a. Was auto	psv	prior to co	ppsy findings available empletion of cause of
Be	The I	Con						1 \( \text{Yes}	ormed? 2 🔀 No	death?	2 🔀 No
ţ	ician: certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		Othe	ace of Death (Chec				
<u>&gt;</u>	Phys r this eral dii	6: 1	1 L Yes 2 X No  27. Manner of Death	1 X Inpatient 2 28a. Date of injury	28b. Time of	it 3 🗆 DOA	4 ☐ Nursing He		dence 6 Oth		(y)
o L	nding ath. :: Afte e fune	icate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	work	? Yes 2 □ No				
Division of Vital Records,	Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Diseases or injury traininted events resulting in death) Last   Cause (Disease or injury traininted events resulting in death) Last   Cause (Disease or injury traininted events resulting in death) Last   Cause (Disease or injury traininted events resulting in death) Last   Cause (Disease or injury traininted events resulting in death) Last   Cause (Disease or injury traininted events resulting in death) Last   Cause or injury training or injury traininted events   Cause or injury traininted events									er or Rura	al Route Number,
Õ	pital ours a eral D		29a. Certifier 1 A Certifying Phys	ician: To the best of my know	ledge death (	occured at the time	date and place as	nd due to the ca	use(s) and man	ner as stat	ed.
	e Hos n 24 h e Fun eleted	Medical	(Check 2 Medical Examin	ner: On the basis of examination	on and/or invest	tigation, in my opinio	on, death occurred a	t the time, date a	and place, and du	ue to the ca	ause(s) and manner stated.
	To th withii To th comp		29b. Signature and title of certifier			29c. License			29d. Date signe	ed (Month,	
				mu	>	D	4695	2_	86	111	
,			30. Name and address of person who c				7 -		(		
	Sta		Sukhjit Singh Si			Dusen R	oad, Laur	el, Mar	ryland 2	0707	
	Sta Registra	ar	31. Date filed AUG 0, 8 2011	32. Registrar's Signa	gar						

Peedomo, Milagros Baltimore, Maryland 21215-0036

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		For	State	e of Marylar	•			and Menta			05100
		State     Registrar			Cer	tificate of <i>E</i>	Death		Reg. N	2011	25132
Physicia	an/	1. Decedent's Name (First, Middle							te of Death onth 🕻 🛭	Day Year	3. Time of Death
Medi	cal	Milagros							_	5 2 Year	
Exami	ner	4a. Facility Name (if not institution, BAHIMORE Wa	shingto	n Medica	1 Center	4b. City, Town, or Glen	Bur	nie			ARUNDEL
Funeral Director		5. Social Security Number 111-46-5035	6. Sex 1 ☐ M 2 💢	7. Age (In yrs.	last birthday)  No. 10 (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	If Under 1 Year Months Days	If Under 2 Hours		te of Birth on <i>th, Day, Year,</i> -07-195	)_ (	irthplace (State or Foreign Jountry) inican Republic
nd <b>now</b> at	٦,	Usual Residence of Decedent  10a, State 10b, County		10c. C	ity, Town or Loc	eation					10d. Inside City Limits
arylar a-fsl	ectc	MD Anne	Arunde		,,		Severn	•			1 ☐ Yes 2 💢 No
the M or 28 e not	Funeral Director	10e. Street and Number	Arunde	1		10f. Zip Code	JEVELI.	.1	10g. (	Citizen of What C	Country?
with s 23a lust b	era	1927 Huguenot	P1ace			21	L144		Un	ited St	ates
death item		11. Marital Status	Armed	Decedent Ever in U d Forces?	.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Orig in, Mexican,	gin? (Specify Ye , Puerto Rican,	s or No- etc.)	14. Race - Am Black, Wh	nerican Indian,
after after xamii	db	1 ☐ Never Married 2 🛣 Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes,		1	X Yes 2 □ No	Specify:	Spanis	h	Specify	lispanic
hours	Completed	15. Deceder	it's Education	or Dates.	16a. Deced	lent's Usual Occup	ation			Kind of Busines	
Z13	l g	(Specify only highe Elementary/Seconday (0-12)	1	ge (1-4 or 5+)		kind of work done o O NOT use retired)	luring most	of working			
With ygien therefore the		, , , , ,		2		Home Mak				Own Ho	ome
Aaryland Z1Z13-UU30 should be filed within 72 hours after death with the Maryland and Mental Hygiene. f is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, L	•					er's Name (First,		n Surname)	
Maryland 21213-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam		Armando Ceped  19a. Informant's Name/Relationsh			10b Mailin	ng Address (Street a		faela G		or Town State	Zin Code)
≥ ○主るで		Bernardo Perdon		band		Huguenot			-		
ore, Marylai 11 and 2 should be of Health and Ment fitem 27 is marked r other traumatic		20a. Method of Disposition	,	20b.	Place of Dispo			Date		Location - City	
Page 1 Thent of ant: If it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		TOTTI State		nd Cemet		08-12-2	011 Br	conx, Ne	w York
<b>ESALTIMORE,</b> permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signatu Funeral 8-yic	icensee	as Più		Name and Address Onaldson 411 Anna					
		28a. Part Enter the disease, or	complications t	hat caused the dea	ath. Do not ente	er the mode of dyin	g, such as o	cardiac or respi	ratory arrest,	Haryra	Approximate
Physician/		shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause o	CAM	4	NO.AL	ann	nmis			Interval Between Onset and Death
Medical Examiner		resulting in death)	a. Due	e to (or as a consec		DO IT C	///	71			
Examiner		Sequentially list conditions,	b. —								
ed	Examiner	if any, leading to immediate cause. Enter ordenying Cause (Disease or iinjury	Due	e to (or as a consec	quence ot):						
xecut n and al-trar	Exa	that initiated events resulting in death) Last	c. Due	e to (or as a consec	quence of):						
ords, P.O. Box 68/60 requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical		d								
os/c ertificat ding ph	Mec	IF FEMALE:									
<b>Box 6</b> death cer he attendi	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 🗆 1	, outcome of pregr Live Birth 2 ☐ Fe Pregnant at time of	tal death 3	Ectopic pregnand Other (specify)	су			23d. Date of o	delivery Day Year
box	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Unknown	rdeath 5						
that the ned by the detach	by Pt	Part II. Other significant condition			_		ven in Part I	l. 2	3e. Did tobacco	o use contribute	to the cause of death?
duires an sign	l be	METAST	かし	OUALIA	CA	CEPL			1 🗌 Yes	2 🗆 No 3 🗆	Probably 4 Unknown
COrds, law requires as been sign	Completed							2	4a. Was an autopsy	prior t	autopsy findings available to completion of cause of
The ate page	200								performed?  Yes 2		? Yes 2 100
ician: Sertific ector,	Be	25. Was case referred to edical examiner?	Hospital:			Oth	or:	th (Check only o			
Phys Phys this ral dir	2	1 Yes 2 No		1 ☑ Inpatient 2 ☐ Date of injury	ER/Outpatier 28b. Time of	IT 3 LL DOA	4 LJ Nu		<ul> <li>Residence</li> <li>escribe how inj</li> </ul>	6 Other (Sp	ecify)
on C nding tth. : After e fune	cate	1 Natural 5 Pendir 2 Accident Investig	g (	Month, Day, Year)	injury	work				,,	
DIVISION OT tal or Attending Pr s after death. al Director: After th ed in by the funeral	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. F	Place of Injury - At h		eet, factory, office			ocation (Street a		Rural Route Number,
LIX ital or its aft ral Dir led in								1			9
DIVISION OT VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical E	xaminer: On the		on and/or invest	tigation, in my opinio	on, death oc	ccurred at the tin	ne, date and pla	ace, and due to th	ne cause(s) and manner stated.
o the	Σ	only one) 3 Gertifying 29b. Signature and title of certifier	Nurse Praction	ner: To the best of r	my knowleage, o	29c. License	e rumber	e and place, and	29d. I	Date signed (Mo	nth, Day, Year)
->-0		150	eli.			No	2537	03	A	AGILAL	5,2011
		30. Name and address of person	who completed	cause of death (Ite	m 23a) (Type, F	Print)	-	<del>1</del>		7	
		BALTIMO	u ce	JASNING	ממפה	MEDICA	te	Con	nn.	GLEN	BURNIEM
Sta Regist		31. Date filed (Month, Day, Year)  AUG 0 8	3 2011	32. Registrar's Sign	atur.	arke					as stated.  nth, Day, Year)  5, 2011  BURNIT MI

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GILBERT J. RUDOLPH 12:19A M AUGUST 0.42011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death BALTIMORE SAINT JOSEPH MEDICAL TOWSON CENTER Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Days 1 X M 2 | F Hours Country) MARYLAND Director 219-22-3782 84 13/1927 Usual Residence of Decedent 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE CITY 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6401 LOCH RAVEN BLVD. 21239 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 2 No within 72 hours after ģ X Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3X☐ Widowed 4 ☐ Divorced WHITE Completed Year or Dates. WWII th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 6b. Kind of Business Industry
DISTRIBUTION—COMMERICAL (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALESMAN YEARS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be file of Health and Mental H If item 27 is marked of r other traumatic ever ည NATHAN CARROLL RUDOLPH GLADYS SHANNAHAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID TEGTMEYER/NEPHEW IANFLEMING CRES. WHITBY. ON L1R2E3 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 8/9/2011 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 21. Signature of Fungral Service Licensee MOO2 17 LOCH RAVEN BLVD. TOWSON. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician CARDIOGENIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 the attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death g Unknown g Unknown P.O. signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 Yes 2 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 2 X No 1 TYes မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation neral Director: / filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ¢ertifie 29c. License number 29d. Date signed Month, Day, Year) H18792 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICELY, 7601 OSLER DRIVE TOWSON, MD 21204 D.O. JAMES C.

6 DHMH 17 Rev 7/2009

State

Registrar

. Registrar's Signa

8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 7:48P M August 2011 Allen Riddle Cathy Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospice Dove House 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Ye Aug. 29, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 🗆 M 2 🔀 F Months Maryland Aug. 50 Director 579-88-5376 Usual Residence of Decedent 10d. Inside City Limits show 10c. City, Town or Location 10b. County at 10a. State Director "natural", or items 23a or 28a-f sl edical Examiner must be notified 1 Yes 2 X No New Windsor Carroll Maryland 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral U.S.A. 21776 4018 Hawks Hill Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian within 72 hours after death 11. Marital Status Black, White, etc Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. White 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) I Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file.
Department of Health and Mental Hv.
Important: If item 27 is mariany injury or other. 17. Father's Name (First, Middle, Last) ဂ္ Magnolia Tanner Elwood P. Thurston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) New Windsor, MD 21776 4018 Hawks Hill Rd. Philip A. Riddle/ husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 8/8/2011 Finksburg, MD 4 Donation 5 X Other (Specify) entombrent Evergreen Mem. Gard. 22. Name and Address of Facility Hartzler Funeral Home Signal le f Fun ral Service Lice ( attarine New Windsor, MD 21776 310 Church St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 NO Other (Specify) Certificate: To 2 XNo 1 Tyes 1 Inpatient 2 ER/Outpatient 3 I within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster, MD 21157 ote 555 S. Center St. 0 31. Date filed (Month, Day, Year) State AUG 08

DHMH 17 Rev 7/2009

Registrar

			For State	State of M	laryland /		rtment of F		and Me	ental Hy	giene	0.0	. 1	05:05
			Registrar  1. Decedent's Name (First, Middle, L	ast)		Cen	tificate of L	)eath	1	2. Date of Dea	Reg. No.	20		25   35 3. Time of Death
	Physicia Media		FRANCIS FRANK	,	СН				'	Month	3	j j	ear OII	5:46 PM
đ	Examir	er	4a. Facility Name (if not institution, ga				4b. City, Town, or	4	of Death	-		. County of		
-	Funeral		Franklin 5940 5. Social Security Number 6.		e (In yrs. last b	oirthday)	ROSE d	○/e If Under		3. Date of Birt	h	g		more place (State or Foreign
l.	Director		215 30 5074	1 🙀 M 2 🗆 F	78	Yrs.	Months Days	Hours	Min. C	977037	193	2	MZ	YLAND
	and show	l	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	ation						1	10d. Inside City Limits
	Maryla 28a-f otified	Director	MO BALT	IMORE	ESS	SEX								1 ☐ Yes 2 🛣 No
	th with the Maryland ms 23a or 28a-f show must be notified at	Funeral D	10e. Street and Number 335 ST. GEORG!	ES ROAD			10f. Zip Code 2122	1			10g. Cit	tizen of Wha	ut Cour	•
9800	s after dea ral", or ite Examiner	کر ا	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 🄀 Divorced	If Yes, Give Year or Dates.	1953	If	√as Decedent of H Yes, specify Cuba	Specify	n, Puerto Ri			14. Race - Black, ' Specify:	White,	etc. USA
15-	72 ho an "na Medic	Completed	15. Decedent's (Specify only highest	grade completed)		(Give k	ent's Usual Occup ind of work done of NOT use retired)	ation during mos	t of working	1	16b. Ki	ind of Busir	ness In	dustry
212	s filed within 72 hour tal Hygiene. ed other than "natul event, the Medical		Elementary/Seconday (0-12)	College (1-4 or	5+)	'NIAN	TENANCE				1st	t MAI	RIN	ER ARENA
Maryland 21215-0036	ould be filed id Mental Hymarked ott	To Be	17. Father's Name (First, Middle, Las FRANK C. RI	t) EMESCH						First, Middle,			Γ	
	1 and 2 should be frealth and Men item 27 is marker other traumatic		19a. Informant's Name/Relationship CAROL RIZZO/FI				g Address (Street ST. GEO							Code) 21221
Baltimore,	permit. Page 1 ar Department of He Important: If iter any injury or oth		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Contents)  21. Signatur ☐ Service Lice	ecify)	ceme	DENS	osition (Name of patory or other place of FAI Name and Addre	TH ss of Facili	8/6/ ty CVA	11 CH/RO	BA) SED	CTIMC	ORE FUN	, MD ERAL HOMI
	<u>σ</u> □ = <b>e</b> ο	Н	23a. Part 1. Enter the disease, or co	omplications that cause	d the death. D					BALT respiratory arr		RE, I	ענא	21237 Approximate
C	Ph_sician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due t (or as	a consequence	hic ce of):	Later						+	Interval Between Onset and Death
	ed nsit	Examiner	Sequentially list conditions, in the light cause. Enter Underlying Cause (Disease or iinjury	b. Due to for as	a consequenc	ce of):							1	
09	ate be executed oblysician and the burial-transit	dical Exa	that initiated events resulting in death) Last	c. Due to (or as	a consequenc	ce of):								
Box 687	death certific ne attending a ed for use as	\ ¥	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2  Fetal de at time of deat	eath 3 🗌	Ectopic pregnand Other (specify)	су				23d. Date		very Day Year
s, P.O.	res that the signed by the	d by Ph	Part II. Other significant conditions	s contributing to death	but not resultir	ng in the ur	nderlying cause gi	ven in Part	I.					the cause of death?
Division of Vital Records,	The law requires ate has been sign age 2 should be	complete								24a. Was auto perfo	osy ormed? _	dea	ath?	opsy findings available ompletion of cause of
tal	cian: Tertifica	Be	25. Was case referred to medical examiner?	Hospital:			Out-		ath (Check o					
of Vi	Physi r this c eral dir	일:	1 ☐ Yes 2 ►No 27. Manner of Death	1 M Inpa	tient 2 ER/	b. Time of	t 3 DOA Oth	4 ∐ N		e 5 Residente la R				y)
on c	ending sath. rr: Afte	ficat	1 Natural 5 Pending 2 Accident Investigation		ay, Year)	injury	work	<br Yes 2 □						
Divisi	Hospital or Attending Physician: The 124 hours after death. Funeral Director: After this certificate beted filled in by the funeral director, page	Il Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	28e. Place of In	jury - At home tc. <i>(Specify)</i>	, farm, stre	eet, factory, office		2	3f. Location (S City or Tov			or Rura	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Medical	(Check 2 Medical Exa	hysician: To the best o aminer: On the basis of lurse Practioner: To the	examination an	d/or invest	igation, in my opini	on, death o	ccurred at the	ne time, date a	and place	e, and due to	o the ca	ause(s) and manner state
	Veith voice		29b. Signature and title of certifier	m			29c. Licens				29d. Da	ate signed (/		
	•		30. Name and address of person wh	o completed cause of	death (Item 22	a) (Tvne D	Res	000	00		\ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>	- 3.	30	11
9/			Ds. Mohamm	ed Alhai	1 900	o Fro	anklin S	guar	e DC:	ve Bo	Itiv	more	~	0 21237
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**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 20 PM Physician/ Riggs Kathleen Η. Medical 4b. City, Town, or Location of Death 3 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Hospita Franklin Square If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Funeral 1 M 2 T Months Days Hours Min. (Month, Day, June 3. Mary and 60 220-62-1030 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director notified 1 🗆 Yes 2 ื No Rosedale MD Baltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral U.S.A. 21237 8901 Talc Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. White 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 X Divorced the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) MD Racing Commission College (1-4 or 5+) Equine Drug Testing Be **Baltimore**, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o ဂ္ Hickey Virginia John Α. Hov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21152 Anne H. Blair-sister 808 Belfast Road, Sparks, MD S. S. 20b. Place of Disposition (Name of 20a Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place.
Hilltop Serv Corp ☐ Burial 2 X Cremation 3 ☐ Removal from State Important: If any injury or once, 8/8/11 Towson, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. ervice Ace 21204 1050 York Rd., towson, MD 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Betweer Onset and Death Immediate Cause (Final Ph\_sician/ Due to hir as a consequence of). disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Mcs 55 Ve 50

Due to (or as a consequence of) and use as the burial-tran the attending physician Completed by Physician/Medical d. Fall Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ≥ 9 ☐ Unknown page 2 should be detached Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Del tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 1 ☐ Yes 2 No Be ( 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ٩ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 🛣No 5 Pending Natural Pt fell while intoricated (alconoi) within 24 hours after death. To the Funeral Director: At 22:00 PM 3/4/11 2 X Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 8901 Tale Drive, BALTIMORE none Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K Re50000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive mara State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sukraj-Smith Radica 9.07 AM 2011 Medical 4a. Facility Name (if not institution, give street and number)
1600 Mt. Royal Avenue Apt. 4<sup>4</sup>b. City, Town, or Location of Death **Examiner** 4c. County of Death N/ABaltimore 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Months 1 M 2 X Days Hours (Month, Day, Year) 213-06-1685 **Director** 19. 1955Trimdad, WI Usual Residence of Decedent or 28a-f show 10b. Count 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director Maryland N/A Baltimore TX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1600 Mt. Royal Avenue 21217 Trinidad, 11. Marital Status 12. Was Decedent Ever in U.S. permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other there any injury or other traumer. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, White, etc. 1 Never Married 2 Married Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ ☐ Yes 2 ☐**X**lo Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Teacher's Aide Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sukraj Latchman Radhia Jagroop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rishi Henry/ Brother 155-13 115th Avenue Jamaica, NY 11434 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Dremation 3 Removal from State 4 Donation 5 Other (Specify) Grèenmount Cemetery Baltimore,MD Signature of Buneral Servi 22. Name and Address of Facility Chatman-Harris Funeral Home Reisterstown Rd Baltimore, MD 21215 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician 9 disease or condition Medical Due to (or as a cons or ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner a consequence of) WS burial-transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant Box 23d. Date of delivery in the past 12 months? Month Day 1 Yes 2 ed by the a detached f 9 🗌 Unknown P.O. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 s autopsy performed Yes 2 death? 1 L Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific, completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Yes 2 No Other: 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident Investigation М Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie -0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 -1/48/A - Eutew 31. Date filed (Month, Day, Year) AUG 0 8 2011 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WILLARD AUSTIN SUMMERS AUGUST 2 10:05A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1 X M 2 🗆 F Months Hours Director 212-48-8762 65 Feb. Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No PA Adams Gettysburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 121 Meade Dr. 17325 U.S.A. and Mental Hygiene.
is marked other than "natural", or items raumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 1965-68 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Computer analyst Federal government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Ethan Phillip Summers Marie LaRue Flook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health Phillip Allen Summers - son 11475 Archer Circle, Monrovia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State . Page 1 permit. Page 1
Department of Important: If it any injury or o 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) All County Cremation 8/3/2011 Sykesville, MD 21. Signature of Funeral Service Lio 22. Name and Address of Facility Hartzler Funeral Home langle 2 KO 310 Church St., New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician. Urose Medical Due to (or as a consequence of): Examiner COVE Sequentially list conditions Oberto for sels, consequence of cause. Enter Underlying by the attending physician and stached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2.3 page 2 autopsy performed: 1 Yes 2 No Yes 2 X N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other:  $_4$   $\square$  Nursing Home  $_5$   $\square$  Residence  $_6$   $\square$  Other (Specify, 2 🗌 No ဂ္ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined the Hospital Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month

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7th Street

s of person who completed cause of death (Item 23a) (Type, Print)

Jaw

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b d.perFH, G918, 8/10/2011, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 0 1 1 Physician/ 5:30P Frances L. Volland 5 Aug Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Pikesville **Examiner** 4c. County of Death Baltimore Woodholme Gardens If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9, Birthplace (State or Foreign **Funeral** Days MD Country) 212-01-4848 1 □ M 2 🛣 F 95 Months (Month Day, Year) 915 Director Usual Residence of Decedent 10b. CountyN/A ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10d, Inside City Limits within 72 hours after death with the Maryland 10c. City. Town or Location Director -Baltimore MD Baltimore 1X Yes 2X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21215 USA 5806 Berkeley Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 XNo ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important If item 27 is marked other than "n:
any injury or other traumatic event, the Medic Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Homemaker Housewife Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Martin H.K. Paulsen Ethel M. Sherick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 708 Eden Farm Circle, Westminster, MD 21157 Joanne V. Clabaugh-niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Kremation 3 Removal from State Sykesville, MD South Carroll Crem 8-7-11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21157 E. Main St., Westminster, MD 254 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph\_ician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and I-tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year the Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an uas autopsy performe Director: After this certificate I 1 Yes 2 No Yes 2X No To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \(\to\) Nursing Home 5 \(\to\) Residence 6 \(\time\)XOther (Specify) Asst 1 Tes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Living 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tix certifie 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 1000 Date filed (Month, State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 25140 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Melvin 2011 3:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GEORGE'S HOSPITAL PRINCE PRINCE CHEVERLY GEORGE'S If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Min SOUTH CAROLINA Months Davs Hours 9/15/1945 65 Director 578-58-4503 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location filed within 72 hours after death with the Maryland Director MD PRINCE GEORGE'S LANDOVER 1 XYes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ıral", or items 23a oı Examiner must be Funeral 2125 COLUMBIA HNITED STATES 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give Year or Dates 2 🗌 No Maryland 21215-0036 1 XYes 2 ☐ No Specify: "natural", Specify: BLACK Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MAINTENANCER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MELVIN E. VIRGIL SR CARRIE VIRGIL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIE VIRGIL/WIFE COLUMBIA PL. 2125 <u>LANDOV</u>ER MD. 20785 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, BRENTWOOD, MD ☐ Donation 5 ☐ Other (Specify) INCOLN CEM 8/6/11 21. Sig 22. Name and Address of Facility CAPITOL MORTUARY re of Funeral Service License MARYLAND AVE NE WASHINGTON 23a. Part 1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Po not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical r as a consequence of) Examiner neumonia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Throat ( or Attending Physician: The law requires that the death certificate be executed ancer that initiated events Due to (or as a consequence of resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed this certificate has ral director, page 2: death? 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Natural 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 08-01-2011

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

405

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2011 8:20 а м EUGENE CLIFFORD WILSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Patuxent River Health & Rehab. Laurel Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Date of Dira. (Month, Day, Year) Country)
North Carolina Months Days Hours Min. 1 X M 2 🗆 F Yrs Director 246-20-4373 May Usual Residence of Decedent 28a-f shov 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 303 Laurel Lakes Court 20707 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Surfacing Installation Elementary/Seconday (0-12) College (1-4 or 5+) and Contracting Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Ira Wilson Mary Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Wilson / son River Shoals Dr. Cartersville, GA 30120 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 
Burial 2 
Cremation 3 
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/3/2011 West Arundel Odenton, 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses 313 Talbott Ave, Laurel MD 20707 M01581 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition metastatic carcinoma of rectum Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) g physician and as the burial-transit Exami Cause (Disease or linjury death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending p IF FEMALE: . nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 4 Pregnant Month Pregnant at time of death 2 🗌 No ed by the a detached f 1 ☐ Yes 2 ☐ Unknown The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 💢 No 1 Yes 2 No Yes Hospital or Attending Physician: Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 🗌 Yes 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending s after death.
I Director: Af 1 Tes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: Of the basis of examination and surface and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar
DHMH 17 Rev 7/2009

State

IDXIV

Baltimore, Maryland 21215-0036

Box 68760

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Records,

**Division of Vital** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

Ramesh Sabapathi,

AUG 0 8 2011

31. Date filed (Month, Day, Year)

D30641

201-109 Back River Neck Rd, Baltimore,

August 2, 2011

MD 21221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** MA LtimoR Medical )a If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday, Days (Month, Day, Year) 0-29-1928 1 □**X**M 2 □ F Hours Min 82 Yrs Director 216-20-6930 MARYLAND or items 23a or 28a-f show miner must be notified at 10a. State 10h County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location Director ROSEDALE BALTIMORE 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21237 1518 BRIAN ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Divorced White Completed Year or Dates. 1946 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) WASHINGTON TIMES LINE TYPE OPERATOR event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ ANDRYHOWSKI ANN WYSOCKI MARY FRANK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21237 1518 BRIAN ROAD ROSEDALE, MD JOYCE WYSOCKI/WIFE other 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/6/11 permit. Page Department HOLY ROSARY CEM BALTIMORE, 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licer see 21237 ROSEDALE, MD 1211 CHESACO AVE Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final nset and Death STELEVATION MYOCAR Physician/ NON disease or condition resulting in death) A11 5 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) ttending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death ped signed by the g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 Tyes page 2 should KidNey 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? has autopsy performed? Yes 2 No hours after death. Ineral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 船 Hospital: Other: 2 No Certificate: To 1 🗋 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar 3

Signature and title of certifie

SARAH

31. Date filed (Me

GOLdBerg

AUG 0 8 2011

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

NPI 1346475191

GREENE STREET Ba

29d. Date signed (Month, Day, Year)

449

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/  $J_{\mathbf{u}}^{Month}$ 2011 Year 20 7:50 A.M Adelaide Isabelle Abe1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Prince Frederick Calvert County Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthdav) **Funeral** 12/14/1919 1 □ M 2 🏋 F Hours Min Washington, DC 91 Director 578-24-7176 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Calvert Chesapeake Beach ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral U.S.A. 3410 20732 Meadow Lane 2 should be filed within 72 hours after death v th and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hy Important: If item 27 is marked ot any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည R. Catherine Thompson James Waple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred M. Abel, husband 3410 Meadow Lane. Chesapeake Beach, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Toremation 3 Pemoval from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 07/20/2011 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. nalos of Funeral Service L 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one care tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Atherosclero Cardio value la direas Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Ducito (or as a consequence of): -transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician a s the burial-Physician/Medical certificate be Box 68760 attending IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Por in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year ed by the P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Heart 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Hospital or Attending Physician: The law requires Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Renal has performed' certificate Dementia 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Division of Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Be in 24 hours affer deaun. he Funeral Director: Affer this ce noleted filled in by the funeral dire မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D.50653 7-20,2011 GUAN C. SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dRW 5851. Church Deale 12 nachDeale 32. Registra s Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PHOHYMA 11:32 PM 700 1105 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE-WASHINGTON MEDICAL CENTER SIMAUB UZUS JEDHUSA UMA Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 XM 2 □ F Days Hours Min. 56 Director 218-62-0287 1954 Maryland Aua. Usual Residence of Decedent 28a-f shov 10b. County 10c. City. Town or Location items 23a or 28a-f sho her must be notified at 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 🗌 Yes 2 🎇 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 USA 203 Westport Bay Drive Apt. 103 12. Was Decedent Ever in U.S. "natural", or item edical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 filed within 72 hours after 1997 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) BWI Airport Signature Flight Support it. Page 1 and 2 should be filed with rtment of Health and Mental Hygier rtant: If item 27 is marked other 1 njury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lydia Sheiko Sebastian Averella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 203 Westport Bay Drive, Apt. 103 Glen Burnie, MD Florence Averella / Wife 20a. Method of Disposition Date 22, 20b. Place of Disposition (Name of 20c Location - City or Town State Department of H Important: If ite any injury or ot cemetery, crematory or other place)
Lakemont Memorial
Gardens 1X Burial 2 ☐ Cremation 3 ☐ Removal from State July Davidsonville, MD 4 Donation 5 Other (Specify) 201ī 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head, failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician. SEPTIC SHOCK disease or condition 2AU0H3 Medical resulting in death) Examiner YAO 1 AIMONUBUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami -transit that initiated events and resulting in death) Last Due to (or as a consequence of) physician a the burial-1 Physician/Medical as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year 2 No the 9 Unknown a Hoknown P.O. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, AMYOTROPHIC LATERAL SCLEROSIS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director; After this certificate h perform ☐ Yes 2 No 1 🗌 Yes of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🗆 No Other: ည 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) nours after death.

neral Director; After the filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natura! 5 Pending Division Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Conference Son Crient seco HD JUCA 16, 2011 P1F53000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUILLERMO JOSE CIANGRECO 301 HOSPITAL DAIVE, GLEN BURNIE, MD 20181-5803 JUL 2 0 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1845 2011 Medical Brumme 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Memorial HOSPITAL TALLOCI FASTON Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 218-48-5951 1 🗆 M 2 😿 F Days Maryland Director Usual Residence of Decedent items 23a or 28a-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MDEaston 1 ☑ Yes 2 ☐ No Talbot 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21601 US A 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ "natural", or 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed ivate Department of Health and Mental High Important: If Item 27 is marked other any injury or other traumatic event, in once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nannie Herman Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) aston MY rumme 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 28 avadise Cometery 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility enry Funeral 510 Washington 21. Signature of Funeral Service Licensee uneral MD121613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed 10-15465 and that initiated events resulting in death) Last burialphysician s the burial Physician/Medical 10-154RS Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown ed by the a detached f 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No page death? 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending injury 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 \*\*Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person

CKNP-8519 Commerce Dn #106 EASTON, MD 2/601

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Month** Year **Physician** 10:17 PM zelle 2011 Bugg /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Mitchellville Villa Rosa Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕅 F April 28, 1942 Arkansas Director 429-92-3028 69 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b, County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 X Yes 2 □ No Director Maryland | Prince George's Landover 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20785 8604 Girard Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XNo Specify: African Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced American 16b. Kind of Business/Industry 1 and 2 should be filed within 72 ho Health and Mental Hygiene. em 27 is marked other than "natui ther traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Data Entry Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Imogene Gibson ၉ Lerov Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20706 8816 Keewatin Road Lanham, Maryland Lottie McClendon - Sister permit. Pages 1 and :
Department of Health
Important: If item 27
any injury or other tr 20b. Place of Disposition (Name of July 28, 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Mary Land
Lerans Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Cheltenham, Maryland Veterans 22. Name and Address of Facility Stewart Funeral Home, Inc. f Fun 6 Service Licensee 20019 4001 Benning Road NE Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ideno curcinoma **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed physician and is the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the detached 9 I Inknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Ves 2 No 3 Probably 4 Unknown 4mphono Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Vascular phercel 24a. Was an has page 2 autopsy performed) certificate 2 No funeral director, 25. Was case referred to medical 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ၉ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No lospital or Attendir 4 hours after death. Funeral Director: A 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical **completely** one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 005333 30 Name and address of person with completed cause of death (Item 23a) (Type, Print) 2835 Smith Anenue Ste 31. Date filed (Month), Day, State JUL 2 6 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ 2011 20, 1:39 P M James S. Bowman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washngton Prince George's 8512 Colonel Seward Drive Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) Months Days Hours Min July 3. Director Yrs. 579-20-1300 88 Usual Residence of Decedent 28a-f shov 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No DC Washington 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5910 First Street NE 20011 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ural", or iten Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert E. Bowman Minnie J. Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 5813 35th Place 20782 Marjorie B. Stewart - Daughter Hyattsville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery crematory or other place) Maryland National Cemetery 1 X Burial 2 Cremation 3 Removal from State July 26, Laurel, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 20 km Tr 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Meatasatic Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Day Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate har al director, page Yes 2 X No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Relative Residence 6 🖾 Other (Specify) examiner Hospital Other: 1 ☐ Yes 2 ☒No <u>ء</u> 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide М 1 Yes 2 No Investigation Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Hospital 24 hours a Funeral I Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kouertchou, m) Jocetyne

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

4041 Powder Mill Road

6 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Calverton, Md.

32. Registyr's Signature

D6374X

July 20, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / L Registrar		tificate of Death		ıııaı myç	Reg. No	2011	25148
	Physicia		Decedent's Name (First, Middle, Last)     AMANDA L. BLUE				. Date of Dea Month IULY	oth Da		3. Time of Death 8:00 P M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location		IOLI	40	. County of Deat	h
	Function		MAGNOLIA CENTER  5. Social Security Number   6. Sex   7. Age (In yrs. last birth	hday)	LANHA		PRINCE GEORGE'S  9. Birthplace (State or Foreign			
	Funeral Director		1 DM 2 DX E	Yrs.	Months Days Hours		Date of Birtl (Month, Day ULY 12	Year)	Co	HINGTON, DC
	aryland a-f show fied at	Director	10a. State 10b. County 10c. City, Town		ation					10d. Inside City Limits 1 ★ Yes 2 □ No
	the Ma or 28a e notil		MD PRINCE GEORGE'S BOWIE	<u> </u>	10f. Zip Code	_		10g. Citizen of What Country?		
	th with	Funeral	11502 WAESCHE DRIVE		20721			US	A	
213-0036	e filed within 72 hours after death with the Maryland ttal hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates.	1	las Decedent of Hispanic C Yes, specify Cuban, Mexic Yes 2 X No Specif		Yes or No- an, etc.)	Diagra, Titis		
<u>.</u>	רס 72 hou. an "nati Medica	Completed	(Specify only highest grade completed)	(Give ki	ent's Usual Occupation ind of work done during mo NOT use retired)	ost of working	- 1	16b. h	Kind of Business	Industry
V	d withir lygiene ther that nt, the	Be Co	10TH	<u>D</u>	AY CARE				RIVATE	
<u>a</u> na	rould be filed and Mental Hy marked oth	To B	17. Father's Name (First, Middle, Last)  JOHN HIGGINS		.	other's Name <i>(Fi</i> DRUSCIL		Maiden IITE	,	
Mary	ha 7 is trau		19a. Informant's Name/Relationship (Type, Print) 19b.	; City o	y or Town, State, Zip Code)					
ore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 9 once.		20a. Method of Disposition 20b. Place of	Dispos		Date			ocation - City or	
baltimore,	iit. Pagartment		4 ☐ Donation 5 ☐ Other (Specify) RESURR	ECT	ION CEMETERY				INTON, MA	
ם ם	permir Depar Impor any ir		21. Signature of Juneral Service Licensee	-1-	Name and Address of Fac	J. D	. JENK HYATTS	INS VIL	FUNERAL LE, MARY	L HOME, INC. LAND 20785
ξ. Σ			23a. Part 1/ Enter the disease, or complications that caused the death. Do no shook, or heart failure. List only one cause on each line.		the mode of dying, such a	as cardiac or re	spiratory arre	est,		Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)  a. STAPH INFECTION Due to (or as a consequence of							
	Examiner	e.	Sequentially list conditions, if any, leading to immediate b. DIABETES  Due to (or as a consequence of							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Exter Underlying Cause (Disease or iinjury that initiated events	1):						
	cate be executed physician and the burial-transit	cal Ex	resulting in death) Last  Due to (or as a consequence of	f):						
2	ificate I ng phys as the	Medic	IF FEMALE:					-		
, DOX 0	the Hospital or Attending Physician: The law requires that the death certificate be executed that 4 hours after death. The Abours after death. The third the Euneral Director and the Euneral Director page 2 should be detached for use as the burial-transit mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1   Yes 2 X No 9   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live Birth 2   Fetal death   Pregnant at time of death   9   Unknown   Unknown   1   Unknown   Unknown	23d. Date of de Month	livery Day Year					
olds, r.O	v requires that the dea s been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in		the cause of death?					
	The law rec cate has be	Completed					24a. Was a autop perfor 1 🔲 Yes	sy me <u>d</u> ?	prior to death?	topsy findings available completion of cause of
פ	rsician s certifi lirector	To Be	25. Was case referred to medical examiner?  1  Yes 2  Hospital:  1  Inpatient 2  ER/Out	Insticut	_ Other:	eath (Check on			Other (6	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Certificate: T	27. Manner of Death 28a. Date of injury 28b. Tir		28c. Injury at work?  M 1  Yes 2	28d	. Describe ho		3 ☐ Other (Spec y occurred	пу)
NEINI	Il or Atte after de Directo		3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	m, stree	et, factory, office	28f.	Location (Si City or Town			ral Route Number,
	e Hospita 124 hours e Funeral	Medical	29a. Certifier 1 Scertifying Physician: To the best of my knowledge, dr. (Check 2 Medical Examiner: On the basis of examination and/or only one) 3 Certifying Nurse Practioner: To the best of my knowle	investig	gation, in my opinion, death	occurred at the	time, date ar	nd place	e, and due to the	cause(s) and manner stated.
	To the within To the comp	<	29b. Signature and title of certifier	2	29c. License number			29 <b>d</b> . Da	ite signed (Montl	n, Day, Year)
			30. Name and address of person who sympleted cause of death (Item 23a) (Ty	VPO P	D68583	3		JU	LY 21,	2011
2	4		TANYECH WALFORD M.D. 9101 SECOND	AVE		SPRING,	MARYL	AND	20910	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrary Signature  JUL 2 6 2011	اريا						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Lisa 9:45 A M Ann Bizzel1 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Ft Washington Medical Center Ft Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 10,1962 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗶 F Days Months Hours MD 49 **Director** 214-84-0651 Usual Residence of Decedent or 28a-f show be notified at filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Accokeek 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 20607 USA 913 Chatsworth Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian rmed Forces Black, White, etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: Black 3 Divorced 4 Divorced Completed Armv Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) perfirit. Page 1 and 2 should be filed within 72 Det artment of Health and Mental Hygiene. Infriortant: If item 27 is marked other than 1 any injury or other traumatic event, the Ma one. Elementary/Seconday (0-12) College (1-4 or 5+) Government Contractor 12TH Medical Supply 2yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph W. Thomas Edith Mae Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 913 Chatsworth Drive, Accokeek, Maryland 20607 Eric Bizzell/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Md Veterans Cemetery 17/29/2011 Cheltenham, Maryland 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 7474 Landover Road, Landover, Maryland 20785 23a, Part 1. Enter the disea shock, high art failure Immediate Cause (Final e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Physician/ MA DC disease or condition Medical resulting in death) conrequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Year Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 **X**No Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yeş 1 Hnpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation Μ 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4  $\square$  Homicide determined 24 hours a Medical 1 Deertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 Certifying Nurse\_Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 2011 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR ARSALAN MIRZA ALIKHANI M.D. 101 CENTENNIAL STREET SUITE B LAPLATTA, MD 20854 31. Date filed (Month, Day, Year) State 2 6 2011

DHMH 17 Rev 7/2009

Registrar

		1	For State Registrar	State of	Marylar		artment o			Mental Hy	giene Reg. N	011	25150
	Physicia	n/	1. Decedent's Name (First, Middle,							2. Date of De Month	ath Day		3. Time of Death
, all the same	Medic	al .	Francine Delo  4a. Facility Name (if not institution,						of Dooth	July	19,	2011 County of Deat	12:30 P.M
	Examin	er	4a. Facility Name (if not institution, 1004 Dannet P		7		4b. City, Tov	r Mar				ince <u>G</u> e	
~	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. i	last birthday)	If Under 1 \	rear If Un	der 24 Hrs.	8. Date of Bir	th	9. Bir	thplace (State or Foreign
М	Director		579-62-4467	1 □ M 2 🔀 F	64	Yrs.	Months D	ays Hou	rs IVIIII.	(Month, Da 06/25/	1947	Shac	lyside,Md.
	oor at	1	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	arylar a-f sl	ectc	Md. Princ	ce George's	I II	pper Ma	arlboro	)					1. Yes 2 No
	or 28 e not	흐	10e. Street and Number	2002 90 2		PP	10f. Zip Co				10g. Citi	zen of What Co	ountry?
	s 23a	Completed by Funeral Director	1004 Dannet B	Place			20	774				U.S.A.	•
	death item	Fur	11. Marital Status	12. Was Decede Armed Force	s?	S. 13. \	Was Decedent f Yes, specify	of Hispanic Cuban, Mex	: Origin? (Sp ican, Puerto	ecify Yes or No- Rican, etc.)	.	14. Race - Ame Black, Whit	
36	after al", or xami	d b	1 ☐ Never Married 2 ★ Marr 3 ☐ Widowed 4 ☐ Divorced	If Man Cine			I ☐ Yes 2	No Spe	cify:			Specify: B	ack
21215-0036	hours natura ical E	lete	15. Deceder	nt's Education		16a. Deced	dent's Usual C	ccupation			16b. Ki	nd of Business	Industry
215	in 72 e. nan "r	E C	(Specify only highe Elementary/Seconday (0-12)	st grade completed)  College (1-4	or 5+)	life. D	kind of work o O NOT use re	one during i tired)	nost of worl	ang			
2	ygien ygien her th	as b	12th			Offic	ce Mana	_				1th Car	<u>e</u>
and	ntal Here	To B	<ol> <li>Father's Name (First, Middle, L</li> <li>Vincent H. De</li> </ol>	*						ne (First, Middle, Wills	, iviaiden s	surname)	
Maryland	ould by mark mark	Ė	19a. Informant's Name/Relationsh			19b Mailir	na Address (S			ral Route Numbe	er. Citv or	Town, State, Zi	o Code)
M	d 2 sh alth ar 27 is ir trau		Craig S. Barkso		đ					Marlbon			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 → Burial 2 → Cremation	2 Demoual from St		Place of Dispo	sition (Name on natory or other	of r place)		Date	20c. Lo	cation - City or	Town, State
Ë	Page ment tant: I		4 Donation 5 Other (S	Specify)	ate		-		mi. 07,	/25/11_	Suit	land,Ma	ryland
3alt	permit Depart Import any inj once.		21. Signature of Funeral Service L	icensee		22	Name and A Henry	ddress of F	ashing	ton & S	ons (	Co.,Inc	•
	40 = 0 O	Н	23a. Part 1. Enter the isease, or	complications that cau	sed the dear	th. Do not ente	925 Bu	rrough	ns Ave	or respiratory a	Wash: rrest.	ington,	D.C.20019 Approximate
	/. Disconing in the /		shock, or heart failure. List o	only one cause on each	line.			-,,,		,			Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)		ne Cai	rcinosa Juence of):	arcoma						17 months
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	n #	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or	as a conseq	uence of):							
	be executed sician and burial-transit	xan	Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (or	as a conseq	juence of):							
0	Attending Physician: The law requires that the death certificate be executed ar death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transitions.	ical Examiner											
	ficate g phys			_ u						· · · · · · · · · · · · · · · · · · ·			
Box 6876	endin	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of pregn th 2 🗆 Fet	ancy tal death 3	Ectopic pre	gnancy				23d. Date of de	-
Bo	death the att	/sici	1 Yes 2X No 9 Unknown	4 ☐ Pregnar 9 ☐ Unknov		death 5	Other (spec	ify)				Month	Day Year
P.0.	requires that the death certificate been signed by the attending phys should be detached for use as the	Completed by Physician/Med	Part II. Other significant condition	ons contributing to dea	h but not re	sulting in the u	inderlying cau	se given in I	Part I.	23e. Did	tobacco u	se contribute t	the cause of death?
	signe d be o	d by								1 🗆	Yes 2	RNo 3□F	Probably 4 🗆 Unknown
ord	requision shoul	olete								24a. Was		24b. Were a	utopsy findings available completion of cause of
ec.	he lav te has age 2	luo l								perf	opsy ormed? 2 🖵 No	death?	s 2 No
a	ian: T irtifica ctor, p	Be C	25. Was case referred to medical examiner?					26. Place of	Death (Che				
Ξ	hysic this ce al dire	은	1 ☐ Yes 2 🗽No			ER/Outpatie			Nursing F	lome 5 😾 Res			cify)
n of	ding F h. After t funera	ate	27. Manner of Death  1 X Natural 5 Pendir	iy .	Day, Year)	28b. Time of injury	M 28c	Injury at work?  1  Yes	2 □ No	28d. Describe	now injury	y occurred	
Sio	Atten r deat ctor:	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of		ome, farm, str							ural Route Number,
Division of Vital Records,	al or safter	Ce	4 - Hornicide determ	building	etc. (Specia	fy)				City or To	wn, State,		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	(Check 2 Medical F	Physician: To the bes	of examination	on and/or inves	tigation, in my	opinion, dea	th occurred	at the time, date	and place	, and due to the	cause(s) and manner stated
	To the H within 24 To the F complet	Me	only one) 3 Certifying	Nurse Practioner: To	the best of n	ny knowledge,	death occurred	d at the time, icense numb	date and pla	ace, and due to t	he cause(s	s) and manner a te signed (Mon	s stated.
	5 × 5 ⊗		29b. Signature and title of certifier	PINI	tr	37		00680				21,20	
			30. Name and address of person	who completed cause	of death (Ite	m 23a) (Type, I						•	
·R	5			Prafrenrot	h,M.D.	. 1221		tile 1	Lane,I	argo,Ma	ryla	nd 2077	4
	Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	istror's Sign	Sarks!							

DHMH 17 Rev 7/2009

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	1	For State		,	State of	Marylan		artment d tificate d			Mental Hy		21111	2515		
	-	Registrar  1. Decedent's Name	e (First, Middle	e, Last)			007	incate c	<i>n</i> DC		2. Date of De			3. Time of Deat	th	
Physician/ Medica	ŀ				CHARLES		VID E	BANKS			July		9 2011		ŢM	
Examiner		a. Facility Name (if					4b. City, Town, or Location of Death Frederick						4c. County of Death Frederick			
Funeral Director	216-38-0759   1 x M 2   F   69 Yrs.   Months   Days   Hours   Min.   Se <sup>(Month, Day, Year)</sup> 1.941   Ma										thplace (State or For puntry) aryland	reign				
ind show at		Usual Residence of 10a. State	Decedent 10b. County			10c. Cit	y, Town or Loc	cation						10d. Inside City Lin	mits	
or 28a-f sho		Maryland		erick	:	Fre	ederick					1 ☐ Yes 2 🛣 No				
with the		10e, Street and Num 81.08 Edge		Churc	h Road	i		10f. Zip Co 21	<sup>de</sup> 702	10g. Citizen of What Country? U.S.A.						
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	3	11. Marital Status  1  Never Marri 3  Widowed	ied 2 ☐ Mai	ried 12	. Was Decede Armed Force 1 A Yes 2 If Yes, Give Year or Date	ent Ever in U. es?	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							14. Race - American Indian, Black, White, etc. Specify: White		
hours natura dical E			15. Decede	nt's Educa	ation	s. 1 0 d 0 ·	16a. Deced	lent's Usual O		on ing most of wo	rkina	16b. i	Kind of Business	Industry		
ithin 72 hours alene. r than "natural" the Medical Exc	5	Elementary/Seco		Jorgiado	College (1-4	or 5+)	life. D	NOT use ret	ired)		g	U	.S. Gov	ernment		
set filed we set all Hygical Hygical Control Control Hygical Control Control Hygical H		17. Father's Name (A	First, Middle,	,	ıks				18. Mother's Name (First, Middle, Maiden Surname)  Betty Jane Williams							
12 should alth and Me 27 is mar r traumati	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or										ral Route Number, City or Town, State, Zip Code) Road, Frederick, MD 21.702					
Page 1 and ent of Hez nt: If item ry or othe	7	20a. Method of Disp 1 Burial 2	☐ Cremation		moval from St	tate	Place of Dispo	natory or other	r place)	v 7/22	Date 2/2011		ocation - City o			
permit. F Departm Importa any inju	4 Donation 5 Other (Specify)  Mt. Olivet Cemetery 7/22/2011 Frederick, Maryla ROBERT E. DALLEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701												, P.A.			
	1	23a. Part 1. Enter t shock, or hear	he disease, o	r complica	ations that cau	used the dear								Approximate Interval Between		
Physician/ Medical		Immediate Cause ( disease or conditio resulting in death)		<b>a</b> .	Due to (or	as a conseq		CANC	ER					Onset and Deatl		
Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying														
executed an and rial-transit	Evall	Cause (Disease or that initiated events resulting in death) I	iinjury s	С.	Due to (or	as a conseq	uence of):								_	
	מונים			d.												
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	ysiciali/ IM	IF FEMALE:   23b. Was decedent pregnant     1														
requires that the de been signed by the should be detached	n by r	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death  1  Yes 2 No 3 Probably 4 Winki														
law requi	naialdilloo										24a. Was	s an opsy formed?	prior to death?		lable e of	
sician: The law is certificate has the lactor, page 2 s		25. Was case referre	ed to medica					2	26. Plac	e of Death (Ch	1  Yes	2 12/1	No 1 □ Y	es 2 No		
Physicial this certail direct	2		No	Hos			ER/Outpatie		Other:	4 ☐ Nursing	Home 5 Res			ecify)		
ending Feath.	licate.	27. Manner of Death  1 Natural 2 Accident	5 Pend	igation	28a. Date of (Month)	injury , Day, Year)	28b. Time of injury	M 28c.	Injury a work? 1 \( \subseteq \text{ Ye}	es 2 🗆 No	28d. Describe	how inju	ury occurred			
The performed?    Part										ural Route Number,						
he Hospii in 24 hour he Funer pleted fill	Medical	(Check 2	Medical	Examiner	: On the basis	of examination	on and/or inves	tigation, in my	opinion.	. death occurre	and due to the o d at the time, date blace, and due to t	and place	ce, and due to the	e cause(s) and manne	r stated.	
To t with To t		29b. Signature and	title of certifie	er ~	hos	pitali	st	29c. Li	cense n	oumber 6413	55	29d. E	Date signed (Mon	th, Day, Year)		
5+ i VA		30. Name and addr	ress of persor	who com	pleted cause	of death (Iter	m 23a) (Type, I	Print)	KII	Tonta						
D ≯ I VA State Registrar		31. Date filed (Mont	th, Day, Year)	2 20	32. R	gistrar's Sign	ature A.	barker	<u> </u>	losp/ta						

11-05299 Robert Baker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 25 | 52

		1- For State Registrar	C	ertificate	of Death		Reg.	No.	11 20101	
Physicia	an/	Decedent's Name (First, Middle,Last)	D - 1				Date of Death     Month	Day Year	3. Time of Death 1122 hrs	
Medical Exami	ner	Robert E.  4a. Facility Name (if not institution, give str	Baker eet and number)		4h City Town	or Location of Death	July 16, 201	1 4c. County of		
		Western Maryland Health Sys	· ·		Cumberla			Allegany		
Funeral		5. Social Security Number 6. Sex		9. Birthplace (State or oreign						
Director		214 36 6442 1XM	Country) MD							
any		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Loc	cation		-		10d. Inside City Limits	
	<u>_</u>	PA Somerset	Co. Me	yersda.	Le				1 Yes 2 No	
Maryland 28a-f show 1 at once	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What	Country?	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.		3441 Greenvil			1555			USA		
ath wit	Funeral	1 Never Married 2 V Married	. Was Decedent Ever in _Armed Forces?			lispanic Origin? ( Sp an, Mexican, Puerto		14. Race - / White, e	American Indian, Black, etc.	
her de		3 Widowed 4 Divorced If Ye	Yes 2 X No	1	Yes 2 X N	o specify:		<sub>Specify:</sub> White		
ours a	d by	15. Decedent's Education (Specify only hi	Dates: ghest grade completed)	16a. Deced	lent's Usual Occup	ation (Give kind of v		6b. Kind of Busir	ness/Industry	
36 in 72 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	1	dworker	B. DO NOT 430 100	lod)	Self em	ployed	
d withing speed	Com	17. Father's Name (First, Middle, Last)		WOOK	JWOL KEL	18.Mother's Name	(First, Middle, Ma		proyec	
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	Clyde Bake	r			Ire				
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	ဥ	19a. Informant's Name/Relationship (Type,				eet and Number or F				
, MD and 2 she ealth and cen 27 is		Thelma Baker / 20a. Method of Disposition	Wife 120b	3441 Place of Disp	l Greenvi	11e Rd.,			15552 ity or Town, State	
Baltimore, permit. Pages la Department of He Important: If ite		1 X Burial 2 Cremation 3 F	Removal from State	crematory or	other place)	Ceme. 7/2	21/11 N	1eyersda	le. PA	
Balting permit. Pa Departmen Importan injury or		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licer see			. Name and Addres	ss of Facility				
Dep Der		William K. D	ino		325 Main	St. W. R	. Price E versdale	uneral PA 155	Home, Inc. 52	
Physician /Medical		23a. Part I. Enter the disease, or complicati failure. List only one cause on each li		th. Do not ente	r the mode of dying	g, such ás cardiac ó	r respiratory arrest	, shock, or heart	Between Onset and	
Examiner			ertensive Atheros		diovascular D	isease			Death	
		Sequentially list conditions, b	to (or as a consequence	oi).						
	iner	if any, leading to immediate Due cause. Enter underlying cause	to (or as a consequence	of):						
=	Examiner	(Disease or injury that initiated events resulting in death) Last	to (or as a consequence	of):						
760, icate be executed physician and the burial - transit		d.								
'60, ate be ex ohysician	Medical		MENDED				-	23d. Date of de	liven	
3876 rtificat ing ph		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 🔲	Fetal death 3	Ectopic pregna	incy	Month	Day Year	
Box 68° e death certificate at the attending ed for use as	Physician/	1 Yes 2 No 9 Unknown 9	Pregnant at time of o	death 5	Other (Specify)					
b.O. Box 68: that the death certifi ned by the attending detached for use as 1	F.	Part II. Other significant conditions con		resulting in the	e underlying cause	given in Part I.	23e. Did toba	cco use contribu	te to the cause of death?	
rds, P.O	d by						1 Yes	2 No 3	Probably 4 V Unknown	
Records, The law require ficate has been si	Completed						24a, Was an autopsy		re autopsy findings available or to completion of cause of	
Che lay	E O				-		performe 1 <b>Y</b> Yes 2	ed? dea No 1 ✓	ith? ✓ Yes 2 No	
Vital Rec ysician: The l his certificate b director, page	Bec	25. Was case referred to medical examiner?				Other				
Division of Vital rat or Attending Physician: rs after death.  al Director: After this certion in by the funeral director.	ဥ	1 ✔ Yes 2 No	<sup>:al:</sup> 1	ER/Outpatie		ury at Work?	g Home 5 Re		Other:	
on of anding Ph	tion	1 Natural 5 Pending	(Month, Day, Year)			Yes 2 No	204. 2000, 20 110	, ,		
visior or Attend her death birector: nn by the	ertification:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, sti	reet, factory, office	building, etc.			or Rural Route Number, City	
Dipital of ours at peral Diffilled i	Cert	4 Homicide determined	(Specify)				or Town, State	e)		
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On t	To the best of my knowle he basis of examination	dge, death occ and/or investig	curred at the time, o pation, in my opinio	date and place, and n, death occurred a	due to the cause(s t the time, date and	) and manner as d place, and due	stated. to the cause(s)	
To wit	Mec	29b. Signature and title of certifier	manner stated.		29c. Licen				(Month, Day, Year)	
		D-VL-			0.0	M.E.	J	luly 17, 2011		
	25	30. Name and address of person who comp			O.M. Palime	Stroot Delli		2		
12	ate	Donna M. Vincenti, MD Ass  31. Date filed (Month, Day, Year)	istant Medical Exa			oueet, Baitin	101e, NID 2122			
Regist		JUL 2 0 2011	Same B.	ture						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup>2011 Physician/  $J_{ulv}^{Month}$ Louise Bubenko 17 2:45 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Goodwill Mennonite Home Grantsville Garrett Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Months Days Hours FeD. 28 <sup>(ear)</sup>1916 Director 95 Pennsylvania 139-14-7466 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Directo 1 X Yes 2 No VA Lowdon Leesburg 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 818 Catoctin Circle NE 20176 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc "natural", or ģ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick William Schleger Augusta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Fred Meyer/Son 3 Stilwater, Swanton, MD 21561 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Union Cemetery July 23, 2011 Leesburg, VA any injury Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 386, Oakland, MD 23a. Part 1. Enter the disease, or complications, pur aused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innertal director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year Pregnant at time of death 1 Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifi 29c. License number 29d Date signed (Month, Day, Year) 153 8 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Thomas Johnson, 311 N.

Month, Day, Year)
JUL 2 0 2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

4th St., Oakland, MD

3. Registrar's Signature

21550

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 527 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ARUNDELMEDICAL ANNE ARUNDE ENTER ANNAPOLIS 5. Social Security Number If Under 1 Year | If Under 24/Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**X** M 2 □ F Months 61 09/15/1949 WASHINGTON, DC Director 578-66-8556 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No MD QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral **403 ELLICOTT DRIVE** 21619 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2**X** No If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural" Completed 3 ¥ Widowed 4 ☐ Divorced Specify: WHITE the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PLUMBER alth and Mental Hygier

27 is marked other to traumatic event, the PLUMBING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JACK M. BROWN ELINOR SOWERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA BRENT / DAUGHTER 115 KENTMORR ROAD, STEVENSVILLE, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
CHESAPEAKE CREMATION
CENTER Department of Important: If it any injury or o ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 07/25/2011 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ PANCREATIC disease or condition CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year signed by the all d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ METASTASIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available has autopsy performed? Yes 2 No prior to completion of cause of death? After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 X Natural 2 Accident 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pendina 1 ☐ Yes 2 ☐ No M Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

death certificate be executed Box 68760 P.O. Division of Vital Records, To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the

the Maryland

within 72 hours after death with

Baltimore, Maryland 21215-0036

29b, Signature and title of certifie PHYSICIAN

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

MD

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

2001 MNAPOLIS

32. Registrar's Signature

State Registrar 29a. Certifier

only one)

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Jun 29, 5:00 A. M Edward Clarence Bracken Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany 11121 M.V. Smith Rd. Flints tone Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 26 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 - F Hours 174242839 **Director** Pennsvlvania Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Allegany ntstone 10e. Street and Number 10g. Citizen of What Country? Funeral 11121 USA 21530 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō Completed by 1 Never Married 2 Married 1 Yes ; If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", Specify: White 3X Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Supervisor Aircraft permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William E. Bracken Florence M. Trimbath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Brant (Daughter) 11121 M.V. Smith Rd. Flintstone, Md. 21530 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 V Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Aug. 3, Smithsburg Cemetery Smithsburg, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral HomeSmithsburg, Md 21783 MO1414 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or linjury Examine Due to (or as a consequence of): the Hospitallor Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events the attending physician and thed for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 JE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Dav Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Tirector After this certificate has performe 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ဂ္ဂ 1 ☐ Yes 2 🛛 No 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manger of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 07 Physician/ 2011 9:45 AM Thomas Charles Bettendorf Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Carroll Hospital Center If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F 579-40-2153 Director 80 Usual Residence of Decedent show 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director other traumatic event, the Medical Examiner must be notified. Carroll New Windsor MD 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21776 USA 2809 Carlisle Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces Black White etc. 1 Never Married 2 X Married 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Korean Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the M-Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland 5+ Geologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Bettendorf Lucetta Rochall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn A. Bettendorf/wife 2809 Carlisle Dr., New Windsor, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 07/30/2011 Cremation Hampstead, MD gnatur f Fymeral Service Licen 22. Name and Address of Facility Pritts Funeral Home & Chapel 21157 412 Washington Road, Westminster, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician il Aled Chesicana o path disease or condition uega Medical resulting in death) Due to (or as a consequence of Examiner lyen Aorhic Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

15 Hoursal Director, After this certificate has been signed by the attending physician and eled filled in by the funeral director, page 2 should be deteched for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 

Ectopic pregnancy in the past 12 months? 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LOPE pleved 2 No 3 Probably 4 Unknown DOST thoracolony sundraine 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined 24 hours a Funeral L 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 231666 1105

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STOMER HUEWE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $J_{\mathbf{u}1\mathbf{v}}^{\mathsf{Month}}$ Physician/ Ε. Arlene 17 8:55 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1502 Lee Way Anne Arundel Edgewater 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 🗆 M 2 🗶 F 8/27/1938 Mary Tand 218-34-4955 Director Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Marvland Anne Arundel Edgewater 10e, Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 21037 USA 1502 Lee Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. 11. Marital Status þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Park Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Grimes Svlvia Hedrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey Coyle/Daughter 884 Kings Retreat Dr.Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Davidsonville, MD 4 Donation 5 Other (Specify) Lakemont Mem'l Garden's 7/21/2011 22. Name and Address of Facility George F. Kalas Funeral Home Signatur Funeral Service Licenses 2973 Solomons Island Road, Edgewater, Md. 21037 alas 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause of each lint caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a co **Examiner** Zeral Cell Carcinoma Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of and I-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last use as the burialthe attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No ģ Month Pregnant at time of death be detached 9 | Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of death? has 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certiffé Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one b. Signature a 20 3 and address of person who completed cause of death (Item 23a) (Type, Print) 3164 Braxistan St. Suite

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death -26-2011 Physician/ 9:00 Lula Mae Blades Medical acility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dice the 0 hirthday) 7. Age (In yrs. last 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD Country) 1 □ M 2 🗶 F Months Days Hours 8-11-1938 2 **Director** 215-36-0715 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location Director 1 ☐ Yes 2X No MD Pocomoke Worcester 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 2735 Sheephouse Road 21851 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 X Never Married 2 Married p If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: SpecifWhite Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Line Production Worker Mid-Atlantic Co. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Howard F. Blades Bessie Mae Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheephouse Rd, Pocomoke, MD 21851 Linda Blades/Daughter 2735 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7-23-2<u>011 Dover, DE</u> Crematory, 22. Name and Address of Facility 917 W. Bennie Smith Isabella St. Signature of Exh Salisbury, Funeral Home 23a. Part + Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISPASR Ph. sician/ CHRONIC KIDNE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** RUPTURA SPONTANROUS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of) physician the burial Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death the 1 ☐ Yes 2 9 ☐ Unknown Unknown signed by the Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/TNo Division of Vital Records, 1 Yes 3 Probably 4 Unknown Completed been si Were autopsy findings available prior to completion of cause of death?

1 
Yes 2 24a. Was an autopsy performed? has certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital HOSPUR 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) : After thi e funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: iniury 14 Natural 5 Pending Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and little of certifier 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cetturan 2180 300 31. Date filed (Month, Day, Year) distrar's Signature State -37 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Edwin Cintron-Medina 07:54 A M 07-Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Coastal Hospice at Salisbury Wicomico the Lake 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 □ F Min. Dec. Apr. Yar 57 Days Hours New York Director 53 584-15-6075 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director an "natural", or items 23a or 28a-f s Medical Examiner must be notified 1 Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2433 West Zion Road 21801 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 XMarried Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced Rican Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) injury or other traumatic event, the Security Guard Retail Mall Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Cruz (Maiden Name Unknown) Nelson Cintron-Medina and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Ginger Lee Cintron-Medina/Wife 2433 West Zion Road, Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Crematory of Delmarva 7/16/2011 4 Donation 5 Other (Specify) Delmar, Delaware e of Full eral Service Light Name and Address of Facility Ller Funeral Home, P. O. Box 3171 12 Old Ocean City Road, Salisbury, MD 21802 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BLADDER CANCER MRTASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2. autopsy performed? Yes 2 prior to completion of cause of death? 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cetturan 31. Date filed (Month, Day, Year) Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 19a State of Maryland / Department of Health and Mental Hygiene 1 - State Amend#'s10b.c.e.f.PerFamilyPCC7-27-11 Certificate of Death 25160 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month S 3011 Cunningham 2315 Gregory Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HESPITAL DATIMY BAMMONE Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Hours Min. May 1960 DC Country) 577-90-4947 51 Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County notified at 10c City Town or Location 10d. Inside City Limits Director Capitol Heights Md **Baltimore** PG 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. ms 23a or must be n 20743 Funeral Pal Kol 21215 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status "natural", or iter idical Examiner þ 1 X Never Married 2 Married 2 X No T Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Carpenter 9th permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lawerence Cunningham Hall LeAnna 19a. Informant's Name/Relationship (Type, Print) Eunice <del>Jackson</del> – Sister Jacobs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7908 Shari Ct Glen Bernie Md 21061 Eunice Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State Riverdale Crematory Aug 1 Riverdale Md 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dunn & Sons Funeral Service 5635 Eads St NE Washington DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ Gastro inteshnal disease or condition d ar Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this continue to the Funeral Director: After this continue to the Funeral Director. and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2**X** N Yes 2 No Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 2 🕃 No 1 Tyes Certificate: To 1 MInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month  $20\overset{\text{Year}}{1}$ William Lewis Craig, Jr. 2:25 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 207 West Street Worcester Berlin Social Security Numbe **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Hours 1**X**□ M 2 □ F Min. (Month, Day, Year) 125/1946 Washington DC **Director** 65 <u>214-46-6578</u> Usual Residence of Deceden ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 207 West St. USA 21811 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces Black, White, etc. 1 X Never Married 2 Married ☐ Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes. Give 3 ☐ Widowed 4 ☐ Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) US Department of Elementary/Seconday (0-12) College (1-4 or 5+) Marketing Specialist Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William L. Craig, Helen Samuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36th St. #407 Ocean City, MD 21842 Ruth M. Duvall / sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cem. 7/27/2011 Suitland, MD of Funeral Service license 22. Name and Address of Facility Burbage Funeral Home 21. Sign yu 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ MOTASTANC LISNG CAUCER Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, accomplications cause. Enter Underlying Examine Due to or as a consequence of Cause (Disease or linjury that initiated events resulting in death) Last and -trans Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à To the Hospital or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No within 24 hours after oeav..

To the Funeral Director: After this c ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State Registrar

EDWIN

Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOWIN (PSIANEDA MID 10324020 & CEAN CITY BLVD, GENLIN, MI) 21811

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-05688 State of Maryland / Department of Health and Mental Hygiene Robert Jeffrey Craig 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month 2111 hrs **Medical Examiner** July 29, 2011 Robert Jeffrey Craig c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Cecil Stemmers Run & Grove Neck Road Earleville If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 10/16/1971 Country Maryland 1XM 2 F 219-78-9000 39 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 v No es I and 2 should be filed within 72 hours after death with the Maryland of Health and Montal Hygiene.

If them 27 is marked other than "natural", or items 23a or 28a-f sho her traumatic event, the Medical E : mingr must be notified at once. Maryland Earleville Ceci1 Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 954 New Cut Road 14. Race - American Indian, Black, Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 Y No specify: Specify: White 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Eiementary/Secondary (0-12) Baltimore, MD 21215-0036 12 Farmer Farming 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Phyllis Barnett Samuel P. Craig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Phyllis B. Craig/Mother 404 Mill Lane, Earleville, MD 21919 20b. Place of Disposition (Name of cemetery, August 4. 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2011 Cecilton, MD Zion Cemetery 4 Donation 5 Other Specify 21. Signature of Funeral Service Licens 22. Name and Address of Fecility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line **IMedical** Death a. Head Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Dievase or injury that initiated events resulting in death) Last Due to (or as a consequence of): - transit and Physician/Medical **AMENDED** attending physician or use as the burial -UNPENDED Division of Vital Records, P.O. Box 68760, so or Attending Physician: The law requires that the death certificate be IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 3b. Was decedent pregnant in the Fetal death 1 Live birth 3 Ectopic pregnancy Month Day Year 2 for use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a I be detached fo Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed his certificate has been a director, page 2 should 24b. Were autopsy findings available 24a. Was ar prior to completion of cause of autopsy After this certificate has performed? ✓ Yes 2 No death? 1 🗸 Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifit completely filled in by the funeral director, i 26.Place of Death (Check only one) 25. Was case referred to medical 品 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 Yes 2 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury Jul 29, 2011 Certification Driver auto fixed object collision 2050 hrs 1 Natural 1 Yes 2 ✔ No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Stemmers Run & Grove Neck Road, Earleville, MD determined (Specify) Local Street Homicide

OCME

State

Registrar

Deputy Chief Medical Examiner Mary G. Ripple MD 31. Date filed /M

29b. Signature and title of certifier

30. Name and addr

900 W. Baltimore Street, Baltimore, MD 21223

erson who completed cause of death (Item 23a)

8 2011

29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 30, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 17 per fh g918 8-8-11 vt
State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM#5perFH, G918, 8/15/2011, WS

Certificate of Death

Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pauline C. Clark 0750 AM August 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WASL instan Medical Center Glen Burnic Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 74 Yrs Funeral 8. Date of Birth 9. Birthplace (State or Foreign Country) MD 34-6290 34-6292 1 □ M 2 🕅 F 01/30/1937 Director sidence of Decedent 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie MD 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1038 Thomas Rd. 21060 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 You No
If Yes, Give Black, White, etc. à 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Credit Accounting 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William David-Clark Evelen Kepper Suter 19a. Informant's Name/Relationship (Type, Print)

James M. Clark / Husband 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1038 Thomas Rd., Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Glen Haven Cemetery tXXBurial 2 ☐ Cremation 3 ☐ Removal from State 08/10/2011 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Preymonia Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or lingury that initiated events resulting in death) Last attending physician and for use as the bunal-trar Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, To the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 흔 2 **X**No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore WAShinston Medical Center 31. Date filed (Month, Day, ¥ear) State Registrar AUG 0 8 2011

DHMH 17 Rev 7/2009

J-LACK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month ULY Physician/ 6:32 AM *බ*ව් / Jessie Ada Clark Medical a. Expility Name (if not institution, give street and numbe 4c. County of Death 4b. City, Town, or Location of Death Examiner APLATA MEDICAL ENTER HARL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y December 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗴 F Months Hours Director 578-26-9275 89 Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours aft r death with the Maryland Funeral Director notified 1 Yes 2 No Maryland Charles Hughesville ms 23a or 2 must be no 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 15665 Cloverleaf Court 20637 USA ral", or items a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Elementary/Seconday (0-12) College (1-4 or 5+) Lab Technician 12th. Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ and 2 should b Martha Armstrong Raymond Fix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15665 Cloverlea<u>f Ct. Hughesville, MD 20637</u> Doris Brown/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 X Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Date 4 Donation 5 Other (Specify) Trinity Memor<u>ial Gardm.</u> July 23. 2011 Waldorf MD 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, M . Signature of Funeral Service Licensee Ny Mellace 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.\_\_\_\_ Approximate Interval Between Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death to the runeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Yes 2 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pendina 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continging Numsa Practioners To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 ority 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who comp ted cause of death (Item 23a) (Type,

State Registrar trar's Signature

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			State of Maryland / Dep	artment of He	ealth and M	ental Hygie	ne	25166		
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	Physicia	an	1. Decedent's Name (First, Middle, Last)			July 16	Day 2011 Year	3. Time of Death		
	/Medic		Nellie Mae Dillsworth	1		July 16	4c. County of Death	10:00AM		
7	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo			Garret			
· ·			1183 Shady Dell Road  5. Social Security Number   6. Sex   7. Age (In yrs. last birthda)	/) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Q Rieth	place (State or Foreign		
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<b>S</b> , <b>P</b>	gned be de	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giver	n in Part I.		acco use contribute to			
ecords,	pluoi					1 Ves				
<u>e</u>	has b	Completed				24a. Was an autopsy perform	prior to	topsy findings available completion of cause of		
						1□ Yes 2	No 1 □Yes	2 No		
Or VITAI Physiclan:	certif	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Othor		n Check onl one	nce 6 Other (Spe	cifu)		
		To : To	27, Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury		28d. Describe hov		ony)		
	ath. r: Afte e fun	atio	Matural 5 Pending (Month, Day Year) Injur 2 Accident investigation		res 2 □ No					
UIVISION Lor Attending	after death.  Director: /	Certification:	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Could not be determined  28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,		
בֿ בֿ	rs after ral DI led in	Cer								
DIVISION To the Hospital or Attending	within 24 hours a  To the Funeral C  completely filled	edical	29a. Certifier (Check only one) (Check o	ath occurred at the tim r investigation, in my op	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)		
the	within 2  To the complete	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License	number	29	d. Date signed (Mon	h, Day, Year)		
ř	- ≯ ⊨ ర		I ( and Kichtery)	03	30035		7/18/11			
		5	30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)	A N					
	<u> </u>	7	GONALD KICKTER 1027	MEMORI	ALDR	OAK	CAND M	0 5120		
		ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature	MEMRI						
Ditt	Regist	rar	JUL 2 0 2011 Santur 1.	1000						

DHMH 17 Rev 1/2001

## Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		For	Plea							a. <b>Ensure</b> <i>i</i> ealth and l				gible.	251	67
	_	<ul><li>State Registrar</li></ul>					Ce	rtificate	of D	eath		Reg. N	ل کے	11	251	01
Physicia	n/	1. Decedent's Name	e (First, Middle		120						Date of D     Month	D	ay	Year	3. Time of	
Medic Examin		4a. Facility Name (if	not institution		JFF d number)			4b. City, Tov	wn, or	Location of Death	200		c. Count	y of Deati	30:05	M A
		BALTIMORE	HZAW-	incton	KEDIC	r ce	ASTU	CLE		BURNIE		JERUNAA HHA				
Funeral Director		5. Social Security Nu 233-40-63	umber	6. Sex 1 \( \text{M} \) 2 \( \text{L}	7. Ag	e (In yrs. I 34	ast birthday) Yrs.	If Under 1 Months C	Year Days	If Under 24 Hrs. Hours Min.	8. Date of B	rth	th 9. Birthpla (Country			Foreign
		Usual Residence of	Decedent								112/20/	192				
iryland I-f sho ied at	Director	10a. State	10b. County				y, Town or Lo					10d. Inside Cit				
the Ma or 28a e notif		MD 10e. Street and Num		Arundel	-	111	llersv	10f. Zip Co	ode			10g. Citizen of What Country?			242110	
is 23a nust b	Funeral	1598 Mil	lersvi	lle Roa	ıd	21108 Unit								d St	ates	
r death		11. Marital Status	ad 2 Mar	Arme	ed Forces?	s? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								ce - Ame	rican Indian, e, etc.	
rs afte iral", c Exam	ed by	3		If Yes	Yes 2X s, Give X or Dates.	21							Specify	Wh:	ite	
72 hou "natu cdical	Completed	(Spec		nt's Education est grade comp	leted)	16a. Decedent's Usual Occupation (Give kind of work done during most of w					orking 16b. Kind of Busi			Business 1	Industry	1
vithin jiene. er thar the M		Elementary/Seco	onday (0-12)	Colle	ege (1-4 or 5	5+) life. DO NOT use retired) Homemaker Own 1						n ho	me			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (F Bruce Di	First, Middle, i shner	Last)						18. Mother's Nar Lucy Gr	ne (First, Middle ubb	e, Maidei	n Surnam	ne)		
should the and Me is mark		19a. Informant's Na								nd Number or Ru						
and 2 s Health em 27 ther tra		Susan G. Duff/Daughter 1598 Millersville Rd. Millersville, MD														
age 1 ent of I nt: If it		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Denation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Atlantic Crematory 7/20/2011 Glen Burn														
permit. F Departm Importar any injur		21. Signature of Fun				110	2	2. Name and A	Address	s of Facility Ha	rdestv	Fun	era1	Hom		
89 <b>=</b> 89			Min		<u> </u>	146				Ave. Ar	napolis	s, M	D 21	401 T		
hysician/		mro diate Caus (F	t fai ure. List ( Final	only one cause	that caused on each line	the deat e.	n. Do not en	ter the mode of	t ayıng	, such as cardiac	or respiratory a	arrest,			Approximate Interval Bety Onset and D	ween Death
Medical Examiner		disclase or condition as a consequence of):														
	er	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):														
executed an and ial-transit	Examiner	cause Enter Underlying Cause (Disease or impury that initiated events c.														
E 2 0																
eath certificate be ex attending physician for use as the burial	ledic	d														
ending use a	an/N	IF FEMALE: 23b. Was decedent			s, outcome			☐ Ectopic pre	anancy	,			23d. D	ate of de	livery	
requires that the death been signed by the atte should be detached for	Physician/Medical	in the past 12 n 1 ☐ Yes 2 🛣 9 ☐ Unknown		4 🗆	Pregnant a Unknown			Other (speci					М	onth	Day Y	/ear
that the	by Pr	Part II. Other signifi		ons contributing	g to death b	out not res	ulting in the	underlying cau	se give	en in Part I.					the cause of de	
requires been sig should b	Completed by	CYD, C	KD				-				1 🗆	Yes			robably 4 🗌 l	
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an: Th tificate tor, pa	Be Co	25. Was case referre	ed to medical						26. Pla	ce of Death (Che	1 🗌 Yes	2 🔀	No	1 Yes	s 2 No	
hysici his cel	유	examiner? 1  Yes 2		Hospital:				ent 3 🗆 DOA	Other	r: 4  Nursing H	lome 5 🗆 Res	sidence	6 🗆 Otl	her (Spec	ify)	
nding Fath. ath. : After t e funera	cate:	<ol> <li>Manner of Death</li> <li>Natural</li> <li>Accident</li> </ol>	5 Pendir Investi	ng	Date of inju (Month, Da		28b. Time o injury	of 28c.	Injury work?		28d. Describe	how inj	ury occur	red		
or Atter	Certificate:	3 Suicide 4 Homicide	6 Could determ	not be 28e. I	Place of Injubul	ury - At ho c. <i>(Specif</i> y	ome, farm, st	reet, factory, of	ffice		28f. Location City or To			ber or Ru	ral Route Numb	er,
to the Hospital or Attending Physician: The law requires that the death certificate be within 24 bours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical (	29a. Certifier 1	Certifying	Physician: To	the best of	my know	ledge, death	occured at the	e time,	date and place, a	and due to the o	ause(s)	and man	ner as sta	ated.	nnor stetad
o the H ithin 24 o the Fi	Mec		Certifying	Nurse Practic				death occurred	at the	n, death occurred time, date and pla number		the cause	e(s) and n	nanner as		mer stated.
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.2		30. Name and addre	ess of person	who completed	cause of d	eath (Item										
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Registra	ar	31. Date filed (Month	UL 20	2011	agun	رس	J. A	are								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 25168 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ronald Edgar Davis 10:34 A<sup>M</sup> Medical July 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Tate Chesapeake Hospice House Linthicum Anne Arundel Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days 1 💢 M 2 🗆 F (Month, Day, Ye) Country) Michigan 217-58-1669 Hours Director 56 Jan. Usual Residence of Decedent Strought of the strength of th permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he activity of one. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8145 Solley Road 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Owner Septic Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Donald Hicks Davis Barbara Daugherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Schappert / Sister 8214 Elvaton Drive Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 22, 1 X Burial 2 Cremation 3 Removal from State Lakemont Memorial Gardens 4 Donation 5 Other (Specify) Davidsonville, MD 2011 Signature of Funeral Service bicensee 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, P.A. Severna Park Funeral Home Severna Park, MD 21146 2 au 23a. Part 1. Enter the disease, or complications that caused the de. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or linjury that initiated events signed by the attending physician and defached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? 4 Pregnant a Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed been si 24a. Was an Were autopsy findings available has page 2 autopsy prior to completion of cause of death? performed 9 Hospital or Attending Physician: The 24 hours after death.
9 Funeral Director: After this certificate I 2 No Yes 2 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 31 Ce 17045 1 Yes ည 2 Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сопрете (Check To the Within 2 To the P 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 25169 State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Donald <sup>Day</sup>**011** Physician/ Lawrence Eastman July 18 7:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Wicomico Fruitland 407 W. Main Street Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🎛 M 2 🗆 F Months Days Hours 63 Director 217-46-0671 Maine Usual Residence of Decedent ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Fruitland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral USA 407 W. Main Street 21826 filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?

X Yes 2 \( \sum \) No Black, White, etc 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 If Yes, Give Army Year or Dates. 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Body Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of r traumatic ever မ Audrey Weidner Donald Irwin Eastman permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print)
Rose M. Eastman/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 W. Main St., Fruitland, MD 21826 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) Q. Phonioway Funeral Home Professional Association (pompoor 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pancroatic cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) 10 months **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): and that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-1 Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ Pregnant at time of death Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed certificate has been si rector, page 2 should ! 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 🗌 Yes 2 🗌 No Yes 2 R No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🛚 No ၉ 1 🗌 Yes After this o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation M within 24 hours after death

To the Funeral Director: ,
completed filled in by the 1 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number July 19, 2011 D70053 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury, Maryland 21801 Yin Wu, mo 100 East Carroll Street 31. Date filed (Month, Day, Year State Registrar

11-05276 Ly

Amend 10e-g, 19b per DVR G919 9/28/11 dk & 10c

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/dia Fisher			e of Maryland							_	1 25171	
dia i ionoi		1- For State	e or iviaryiand			of Dea		Wientan	-	201	1 25171	
Physici		1. Decedent's Name (First, Middle,L	,			0, 500			2. Date of Dea Month	eg. No. th Day Year	3. Time of Death	
ledical Exami	iner	Lydia Mae Fish		)		4b. City	, Town, or Lo	cation of Deatl	July 15, 2	4c. County of	0815 hrs	
		Western Maryland Healt		,		Cur	mberland			Allegany		
Funeral Director	П			ge (In yrs. I	ast birthday	y) If Ur Mor	nder 1 Year hths Days	If Under 24Hrs Hours Mir		i i	9. Birthplace (State or oreign	
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7 any		10a. State 10b. County		10c. City,	, Town or L	ocation					10d. Inside City Limits	
Aaryland 28a-f show 1 at once.	ţo	PA Somer	set	Spr	ings.		Salis	sbury			1 X Yes 2 No	
or 28a	Director	10e. Street and Number 383 Fisher Rd.				- 1	<sup>2</sup> ip Code 5562	15558	1	0g. Citizen of What Country? USA		
with the nas 23a be noti		11. Marital Status	12. Was Decedent		.S. 13.	. Was Dece	dent of Hispa	- 14. Race - A	American Indian, Black,			
r death or ite	Funeral	1 X Never Married 2 Marri	1 Yes 2	No				Mexican, Puerto	Rican, etc.)	White,		
urs afte tural", pniner	d by	3 Widowed 4 Divorce  15. Decedent's Education (Specify	ed If Yes, Give Year or Dates: only highest grade cor	npleted)	16a. Dece	edent's Usu		(Give kind of		Specify: 16b. Kind of Busin	White ness/Industry	
6 72 hou ra "nas	etec	Elementary/Secondary (0-12)	College (1-4 or	5+)	durin	ng most of w	orking life. D	O NOT use ret	ired)			
5-0036 ed within 72 hor hygiene. other than "nat	Completed	8 17. Father's Name (First, Middle, La	ctl		Hom	emake		Mother's Name	- /First Middle I	Owi	n Home	
21215-0036 Auld be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	Noah B. Fisher	51)						etershei			
_ 27 = 1	2	19a. Informant's Name/Relationship			19b. Ma	ailing Addre	ss (Street a	nd Number or Salis	Rural Route Nun	nbq 55558Town,	State, Zip Code)	
and 2 sho lealth and tem 27 is traumati		Daniel Fisher/Br 20a. Method of Disposition	other		Place of Dis	sposition (N	ame of ceme		Date		ity or Town, State	
Baltimore, permit. Pages 1 an Department of He Important: If ite injury or other tr		1 Burial 2 Cremation		are	_	or other place	etery	71175	z 18., 20	       Salis	oury, PA	
Baltimo permit. Page Department o Important: injury or oth	1	4 Donation 5 Other Speci 21. Signature of Funeral Service Lic		1112	2	22. Name ar	nd Address of	Facility Ne	ewman Fu	neral Ho	mes, P.A.	
		23a. Part I. Enter the disease, or cor	noticed that forward	the death					ntsville		536 Approximate Interval	
Physician Medital		failure. List only one cause on	each line.						or respiratory and	est, shook, or near	Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Complica Due to (or as a cons			RHCC	Injury					
	-e	Sequentially list conditions, if any, leading to immediate	b Due to (or as a conse	equence of	f):							
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Box 68760, s death certificate be the attending physicied for use as the buri	N.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	ne of pregr	nancy 2 $\square$	Fetal deat	h 3 🗌	Ectopic pregna	ancy	23d. Date of de Month	livery Day Year	
ox 6 eath cer attendi	sicia	1 Yes 2 No 9 V Unknow	4 Pregnant at	time of de		Other (Sp	ecify)			a contract		
R E		Part II. Other significant conditions		h but not re	esulting in the	he underlyir	ng cause give	en in Part I.	23e. Did to	becco use contribu	te to the cause of death?	
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Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the finneral director, page 2 should be	Completed								24a. Was autop	sy pric	re autopsy findings evailable or to completion of cause of oth?	
tal Rec	8								1 ✔ Yes		Yes 2 No	
Vital Rec hysician: The I this certificate I d director, page	B	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatie	ent 2	ER/Outpati	ient 3		Death (Check		Residence 6	Other:	
n of \ing Phy	5	27, Manner of Death	28a. Date of Inju (Month, Day,Y		28b. Time		28c. Injury a			now injury occurred	· <del></del>	
Sion Attendi death. ctor:	atio	1 Natural 5 Pending 2 X Accident Investiga	unknow	n	unkn		unkno	Wn		t twiste		
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Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.		29a. Certifier (Check only 1 Certifying Physic	clan: To the best of m	y knowledg	e, death o				due to the caus	e(s) and manner as		
To the within To the comple	Medical	one) 2 Medical Examin  29b. Signature and title of certifier	er: On the basis of examination and manner stated.	mination ar	nd/or invest		ny opinion, de 9c. License n		at the time, date		(Month, Day, Year)	
		200. Signature and title of certifier	1		1	2p1	O.C.M.I			July 16, 2011		
	ŀ	30. Name and address of person who	completed cause of d	eath (Item						<u> </u>		
		Russell Alexander MD.	Assistant Medic			00 W. Ba	Itimore St	reet, Baltim	nore, MD 212	223		
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BRIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yea Physician/ 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Grantsville 985 Springs Rd. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex **Funeral** Age (In vrs. last birthday) (Month, Day Ye Days 1**X** M 2 □ F Hours Min. Year) 1945 266-82-9916 65 Illinois Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location Director 1 Yes 2 X No MD Grantsville Garrett 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21536 985 Springs Rd. USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: White Specify: Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Publishing Co. Pressman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Henry James Forst Katherine Masek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 985 Springs Rd., Grantsville, MD Christina Diane Baker/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State Country Side Crematory July 20, 2011 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Newman Funeral Homes, P.A. Box 275, Grantsville, MD 21536 Approximate 23a. Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deal
4 ☐ Pregnant at time of death
9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 L 9 Unknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 70 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No Yes 2 W Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 100 Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Dav. Year)

Registrar

State

30. Name and address of person who

JUL 2 0 2011

31. Date filed (Month, Day, Year,

215

ause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MALONE FREW KAREN 0230 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL Social Security Numbe If Under 1 Year If Under 24 Hrs . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours 04/21/1945 Director PENNSYLVANIA 221-28-7421 66 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
I tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3013 LOVE POINT ROAD UNITED STATES 21666 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes Give 3 Widowed 4 Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MEDICAL BILLING MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DANIEL MALONE KATHRYN DOYLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a ROBERT EDGAR FREW / HUSBAND 3013 LOVE POINT ROAD, STEVENSVILLE, MD 21666 Page 1 and 2 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CHESAPEAKE CREMATION 07/21/2011 ò permit. Page Department o Important: If any injury or STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signal re f Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
106 SHAMROCK ROAD, CHESTER, MD 21619 HOME, P.A. Jan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ouset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Cardin Vascular Callapse 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy performed? 1 🗌 Yes Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5  $\square$  Pending 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Date signed (Month, Day, Year) 21438 V Cha 2011 20 Completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

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Amended item #1 per Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. physician, 7/26/11; cs State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)

Deborah

Kay 2. Date of Death 07 Month Physician/ 19<sup>Day</sup> Kay Gaither 2011 ear Medical 18:05 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Garrett County Memorial
5. Social Security Number | 6. Sex | Hospital 0akland Garrett **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 07 02 9. Birthplace (State or Foreign 1 🗆 M 2 🗷 F Months Days Hours Director 234-86-1689 1952 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at ane. Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County by Funeral Director 10c. City, Town or Location 10d. Inside City Limits Garrett 1 X Yes 2 No Mt. Lake Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 Heritage Drive 21550 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 ☐ Yes 2 X No Yes, Give 1 ☐ Yes 2 X No Specify. 3 Divorced 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Adm. Assistant</u> Medica1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Simmons <u>Dolores Foreman</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Gaither-husband 706 Heritage Drive, Mt. Lake Park, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 **X** Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (*Specify*) Cumberland Crematory: 7/22/2011 | Cumberland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit David A. Burdock Funeral Home P.A. 21 N. 2nd St, Oakland, MD 21550 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on). Exami attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death been signed by the a should be detached to Month Day 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Inpatient 2 ER/Outpatient 3 DOA 1 Tes မ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of Hospital or Attending 28c. Injury at 28d. Describe how injury occurred Natural Natura. 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide Could not be 24 hours after of Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Pwithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23979 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert A. Goralski, M.D., 311 North Fourth St, Suite 11, Oakland, MD 21550 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar

leather Greer	State of Maryland / Depa	artment of Health and Mental H	veiene · ·	2517						
		rtificate of Death	ygiene 2011	2517						
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)  Heather Nicole	Greer		3. Time of Death 1717 hrs						
	4a. Facility Name (if not institution, give street and number) University of Maryland Medical Center	4b. City, Town, or Location of Death Baltimore								
Funeral	Social Security Number 6. Sex 7. Age (In yrs. In									
Director	217-49-3713 1 M 2XF 14	Yrs. Months Days Hours Min	04/21/1997 Foreign	ntry) MD						
An a		Town or Location		10d. Inside City Limits						
Aaryland 28a-f show 1 at once. Octor	MD Harford  10e. Street and Number	Pylesville	10g. Citizen of What Coun	1 Yes 2 X No						
D Life	5006 St. Pauls Church Ro			U.S.A.						
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urs aft fural" amine	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of	Usual Occupation (Give kind of work done 16b. Kind of Business/Indo							
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215-( be filed v ntal Hygi rked oth ent, the	Jesse L. Greer		Tina L. Salser							
D 21215-0036 should be filed within 72 hou and Mental Hygiene. 7 is marked other than "ma artic event, the Medical Example To Be Completee.	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or I								
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumatin	Jesse L. Greer / Father  20a. Method of Disposition   20b. 8	5006 St. Pauls C	Date 20c Location - City or 7							
10re ages 1 nt of H other	Tablia 2 Cientation 3 Tentoval non otate	rrisville United Au	g. 4,	מא וו						
altin mit. P. partme portau	4 Donation 5 Other Specify: Norrisville United 2011 White Hall Methodist Cometery 2011 White Hall Signature of Funeral Service Licens 10 Service Licens 110 Service Main St.									
	was or -	1 19 South Main St	., Stewartstown, Pr	4 T/202						
Physician // // // // // // // // // // // // //	23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.	. Do not enter the mode of dying, such as cardiac o	r respiratory arrest, snock, or neart	Approximate Interval Between Onset and Death						
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence or	f):								
	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence or	£)·		<u></u>						
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8760, ifficate be ng physicii ss the buria	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of preg	nancy  2 Fetal death 3 Ectopic pregna	23d. Date of delivery ancy Month D	ay Year						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burned of the completely filled in by the funeral director, page 2 should be detached for use as the burned of the completely filled in by the funeral director, page 2 should be detached for use as the burned of the complete of the completed by Physician/Med	past 12 months?  4  Pregnant at time of de  1  Yes 2  No 9  Unknown 9  Unknown									
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ital Recician: The la secrificate harector, page			1 ✓ Yes 2 No 1 ✓ Yes	2 No						
fital F sician: is certifi lirector, j	25. Was case referred to medical examiner?  1 Was 2 No   Hospital: 1   Inpatient 2	26,Place of Death (Check ER/Outpatient 3 DOA Other Nursin	only one)  ng Home 5 Residence 6 Other:							
of Ving Physical After this Inserted dir	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred Pedestrian struck by motor veh	icle						
Sion Attendi death. ctor:	2 Accident Investigation Jul 28, 2011	FOUND: 1								
Division o ospital or Attending hours after death hours and meral Director: After the fine of the fine	3 Suicide 6 Could not be determined (Specify) Roadway	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rur or Town, State) 2200 block of Harkins Road, Pylesv							
To the Hospi within 24 hou To the Funer completely fil	20a Certifier	ge, death occurred at the time, date and place, and	<del></del>							
To the How within 24 h To the Fun completely	one) 2 Medical Examiner: On the basis of examination a and manner stated.		· · · · · · · · · · · · · · · · · · ·							
<b>△</b>	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Mon July 29, 2011	(⊓, ⊅ay, Year)						
	30. Name and address of person who completed cause of death (Item									
V	Carol Allan, MD Assistant Medical Examiner	900 W. Baltimore Street, Baltimore, M	D 21223							
State Registrar	31. Date filed (Morith, Day, Year)  AUG 0 8 2011	1. parl								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 16, 2011 a Gray, III 5:45 РМ Duryea D. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Day, Ye June 03, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday **Funeral** 1940 1 X M 2 □ F Months Days Hours Virginia 227-50-9415 71 Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must he notified at 10a. State 10b. County 10c. City. Town or Location Directo Severna Park Anne Arundel MD 1 Tes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21146 509 Bayberry Drive Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Energy Research Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Wingo ပ Duryea D. Gray, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spotsylvania, VA 22551 8911 Millwood Drive Elizabeth Hunziker / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 18, ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory, INC: 2011 4 Donation 5 Other (Specify) Signatu 22. Name and Address of Facility Barranco & Sons, Severna Park Funeral Home P.A. Severna Park, MD 21146 495 Ritchie Hwy. complications that caused the death. Do not enter the mode of dying, 23a Part 1. Enter the disease, of shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi). Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicial mpleted filled in by the funeral director, page 2 should be detached for use as the buri Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 🗌 No 1 Yes 25. Was case referred to cal Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည ER/Outpatient 3 DOA 1 Inpatient 2 Certificate: 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Accident Investigation 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after

To the Funeral Dire

completed filled in b Medical Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month 29b. Signature a completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, 2 0 2011 JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20<sup>ay</sup> Month July 201<sup>ea</sup> David Lee Handlev 8:30 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge Dorchester Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1ay 31, 1937 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Months Hours Min. 1 X M 2 D F Maryland 215-38-0051 74 **Director** Usual Residence of Decedent at 10a, State 10c. City. Town or Location 10d. Inside City Limits Director MD Dorchester Cambridge 28a-f 1 Yes 2 X No Examiner must be notifi with the I 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ö Funeral items 23a 4428 Maple Dam Road 21613 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 0 þ 1 Never Married 2 X Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) freight truck driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ should be William Watkins Handlev Susie Willey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Meridith Handley wife 4428 Maple Dam Road, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State or o 1 X Burial 2 Cremation 3 Removal from State injury o 4 Dogation 5 Other (Specify) Dorchester Mem. Park 7/25/11 Cambridge, MD 22. Name and Address of Facility 21. Signatura of Funeral Service Licenses Thomas Funeral Home P.A. any 700 Locust St. Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a conseque Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Year 2 🗌 No a 🗌 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 ☐ No 3 ☐ Probably 4 X Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗆 Yes 2 🗆 No Yes 2 Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

32. Registra

2

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 July 20, 5:00 A M Eugenia O. Harris Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Ft. Washington Rehabilitation Center Ft. Washington 5. Social Security Number If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Yes 1 🗆 M 2 🏋 F Min 1915 South Carolina Director 248-20-2020 95 Sept. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6000 Sargent Road 20782 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: If Yes, Give Year or Dates Black. Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Nurse other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ပ္ Lillian Leake James Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 22044 Falls Church, VA 3154 Ravenwood Drive Phylis J. Adams - Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or of July 26, 2011 1 Burial 2 Cremation 3 Removal from State Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Signature & Fune a Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Vira 4001 Benning Road NE Washington, DC 23a. Par. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arterioslerotic Heart Disease disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown Month Day Year 5 Other (specify) Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate Yes 2 XN 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 🗵 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 XNursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Investigation Accident 6 Could not be determined Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, the Hospital or Attending within 24 hours after deat To the Funeral Director: To the Fund

Box 68760

P.O.

State Registrar

29b. Signature and title of certifier

2 6 2011

11701 Livingston Road William T. Tanner 31. Date filed (Month, Day, Year)

Cerrie my

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c License number

D35206

Fort Washington, Md.

29d. Date signed (Month, Day, Year)

July 21, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No U Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month () Day Physician/ Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, Examiner . Age (In yrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Months Feb. 5 1926 Maryland 215-20-8416 85 Director Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be ı Funeral U.S.A. 21702 8951 A Indian Springs Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White "natural", Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Auto Repairs Auto Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) ပ Chloe Linton Russell H. Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Mercer Court, Unit 213, Frederick, MD 21701 Stephen Harris / Son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Smithsburg Crematory 1 Burial 2X Cremation 3 Removal from State Smithsburg, Maryland 7/21/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service. Licen ee rôbert<sup>ade</sup>Daftey & son funeral homes, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Ph. i i n disease or condition Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events and burial-trar resulting ( death) Last attending physician Physician/Medical that the death certificate be 68760 IF FEMALE ISe yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d ate of delivery Box ( 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death the P.O. signed by Part II. Other significant conditions contributing to death 🗤 not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Vital Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗆 No 1 Npatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Dly, Year) o the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After t or Attending 5  $\square$  Pending 1 
Natural Division 2X No 1 Tyes Investigation Accident hours after death 3 Suicide Could not be ace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Ros completed filled in by 4 Homicide determined within 24 hours a To the Funeral L Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29c. License number se of death (Item 23a) (Type, Print)

State Registrar

Greene

strar's Signature

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St. Baltimore M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 25,27,28a-f per me 8920 10-12-11 yt State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $Ju^{M\rho nth}$  19, 2011 7:03 P M Norman Lee Horman Medical 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Citizens Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days (Month, Day, Y April 8, Maryland 89 1922 **Director** 219-10-6123 Usual Residence of Decedent 28a-f show 10d. Inside City Limits death with the Maryland ıral", or items 23a or 28a-f sho Examiner must be notified at 10a State 10b. County 10c. City, Town or Location Director Frederick 1 ☐ Yes 2X No Frederick Marvland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 21703 6441 Jefferson Pike 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status was becedent Ever III o.s. Armed Forces? 1 ▼ Yes 2 □ NoWWII If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced White 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Furniture Upholstery **Upholster** Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) ಲ Mildred Price Elmer Horman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 st of Health a 3006 Roderick Rd./Frederick, Maryland 21704 Debra Flook / Niece Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State Resthaven Mem. Gardens 07/22/2011 Frederick,MD 21702 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home, P.A. 1621 Opossumtown Pike/Frederick, MD 21702 23a. Part 1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner Due to for as a consequence on if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events PEROVED BY the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death
Unknown 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 W Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred -tural 5 Pending 1 🗌 Yes 2X No 2 X Accident 6-26-2011 unknown M Investigation subject fell 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6441 Jefferson Pk. 20—B Frederick, Md. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Assisted Living Facility Hospital within 24 hours a Medical ☐ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person A+ IVA State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 2011 6:58 P M HENDERSON MADELINE M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK HOSPITAL FREDERICK MEMORIAL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept. 3, 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Hours Massachusetts 1 □ M 2 🕱 F 88 **Director** Sept. 024-16-8242 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 200. any injury or other traumatic event, the Mariania". 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7401 Willow Road Apt. 271 21702 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) National Elementary/Seconday (0-12) College (1-4 or 5+) Bureau of Standards Chief of Information Section Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Irene Murphy Burton Berry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 406 McClellan Drive, Frederick, Maryland 21702 Laura Hicks/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Frederick, Maryland. 4 Donation 5 Other (Specify) Crematory Inc.7/26/2011 Stauffer Signature of uneral Service Li 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes P A Pike, Frederick, Maryland 21702 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OTIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes ၉ 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. 2. No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7/12/4 70976 and address of person who completed cause of death (Item 23a) (Type, Print eff 400 W-25 amiran fluo Frederick. egistrar's Signature State Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Year  $\operatorname{July}^{\operatorname{Month}}$ Physician/ Henry Marshall Hair 11, 11:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Edgewater South River Nursing Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Jan. Pay, Year 25 1 🛛 M 2 🗆 F Hours Min 86 North Carolina Director 243-42-7691 Usual Residence of Deceden ul Hygiene. I other than "natural", or items 23a or 23a-f sho vent, the Medical Examiner must be notified at. 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Maryland Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Carrol1 21787 9 Bison Street within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status rmed Forces?

Yes 2 No Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 🛮 No Specify. Specify: White 3 K Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Master Carpenter event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is many injury or other. ၉ Linda Baker Braston D. Hair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code) 9 Bison St., Taneytown, MD 21787 Richard Klass/Son-in-Law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July I6, cemetery, crematory or other place)
Resthaven
Memorial Gardens 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2011 Frederick, Maryland 21. Signature Funeral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure fails only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final disease or condition Physician/ Vascular Dementia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Exam attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No. 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Dysphagia 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Aortic Vascular Disease has autopsy performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 1 Yes 2 No To Be 25. Was case referred to medica 26. Place of Death (Check only one) 2X No 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 1515 53411 2011

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Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 17ay 12:39 AM 20<sup>Yea</sup> HERBERT LEROY HOVERMALE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Thurmont 12539 Layman Road Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Nov. 5, 1.930 1 🖫 M 2 🗆 F Months West Virginia 80 Director 232-32-5258 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 🗆 Yes 2 🔀 No Frederick Thurmont Maryland 10e. Street and Number 10f, Zip Code 10a. Citizen of What Country? Funeral U.S.A. 21788 12539 Layman Road death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Forces?

1 XX Yes 2 \( \subseteq \) No Black, White, etc. or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🛣 No Specify: "natural", 3 ☐ Widowed 4 🏋 Divorced White Completed Year or Dates. Korea 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meaonce. Elementary/Seconday (0-12) College (1-4 or 5+) Rental Owner & Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Hovermale Agnes Dawson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12539 Layman Road, Thurmont, Maryland 21,788 19a. Informant's Name/Relationship (Type, Print) Sheila Burkhart / Niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garfield Church Cem. 7/26/2011 Wolfsville, Maryland 4 Donation 5 Other (Opacify) Signature of Fune al Service Lice pee ROBERT Edre DATLEY & SON FUNERAL HOMES, KURZZ 615 EAST MAIN ST., THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Adenoid Immediate Cause (Final ancinoma Pnysician/ Yen1 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to or as a consequence of cause. Enter Underlying and -transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burialnding physician use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burnant. Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home & Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 003575

State Registrar CENTE

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Mont)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Hilda Grace Harrison 201 Medical :00 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 266A Little New York Road Ceci1 Rising Sun 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1 □ M 2 🖾 F Days (Month, Day, ) .1930 213-28-6920 81 North Carolina Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Cecil Rising Sun 1 Yes 2 No P 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 85 Westwood Road 21911 U.S.A. 1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give ō ģ 1 Never Married 2 Married 72 hours after 1 ☐ Yes 2 X No Specify. "natural", Specify Completed 3 X Widowed 4 Divorced White Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmetr. Elementary/Seconday (0-12) College (1-4 or 5+) Eight Years Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Raymond Marcom Lessie Sorrell 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Westwood Road, Rising Sun, Maryland 21911 Dale Harrison (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Bel Air
Memorial Gardens 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/28/11 Bel Air, Maryland Signature of Funeral Service Licer 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Senile disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No 5 Other (specify) Month Day Year Pregnant at time of death the detached g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 👿 No 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 🗓 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending n 24 hours after death.

e Funeral Director: Aft eleted filled in by the fur 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

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within 2

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Monard

2011

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Hospital

Ronald Thomas, M.D., 3445 East Box Hill Corporate Ctr., Drive, Abingdon, MD 21009 32. Registrar's Signature

Ames 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DOOZ4318

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ruth Lane Hales Medical 4a. Facility Name,(if not institution, give street and number 4c. County of Death Examiner Comico Date of Birth If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Year **Funeral** Min Maryland 1 🗆 M 2 🕱 F Months Days Hours 03/03/1933 78 214-30-7828 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified. 1 🗆 Yes 2 ื No Salisbury Maryland Worcester 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral USA 21804 7608 Snow Hill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc 1 Never Married 2 Married Completed by White 1 Yes 2 X No Specify: Yes. Give 3 XWidowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk District Court Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Fanny Byrum Jesse William lane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32042 Jordan Ct., Salisbury, MD 21804 Deborah Johnson/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State springhill Memory
Springhill Memory 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 7/21/2011 4 ☐ Donation 5 ☐ Other (Specify) Hebron, MD 21. Sign Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final disease or condition ell Ph<sub>sician/</sub> Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Fifter Underlying Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) ttending physician or use as the burial Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 poinths?

1 Yes 2 No
9 Unknown Month Vear Day Pregnant at time of death ed by the detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 21 No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 180 υ 1880 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

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				ATLANTIC 5. Social Security Nu		AL HOSP		(In ure la	st birthday)	If Under	IRLIN	If Under	r 24 Hrs.	3. Date of Birl	th	WORCES		ace (State or Foreign
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^	anc	be filed ental Hy ked oth ic event	10	GILBERT	H.	HAYDEN						MARY		First, Middle, LLIAN		Surname) ROSSLEY		
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1	altimore,	t. Pag tment tant: ijury o		4 Donation	5 Other (S	pecify)		RED	CLAY C				7/25	/11	WIL	MINGTON	<b>,</b> [	)E
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Physici ledical Exami		Decedent's Name (First, Middl		ner						Date of Do Month July 17,	eath Day	Yea		3. Time of Death 0819 hrs	Ī
		4a. Facility Name (if not institutio East Route 70 @ Rou	-	umber)			Town, or Lo	ocation of	Death			. County o	f Death		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. I:		If Und	der 1 Year hs Days	If Under Hours	24Hrs. 8 Min.	3. Date of I	Birth(MM/	3	9. Birtl Foreigr Cou	place (State or Washington, ntry) DC	,
uyland a-f show any at once.	tor	213-44-4157     Usual Residence of Decedent   10a. State   10b. County     Maryland   Alleg		10c. City,	Town or Loc	ation <b>V</b>	lester	npor		00/1				10d. Inside City Limi	
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Director	10e. Street and Number 22508 Horse Roo				2	1562				Unit	zen of Wh	tate	S	
	by Funeral		arried Armed F  1 X Yes orced If Yes, Give Yes or Dates:	2 No	lf	Yes, spec	ent of Hispa ify Cuban, M	Mexican, I specify:	Puerto Rio	can, etc.)		14. Race White Specify:	, etc. Whi		
11215-0036 Id be filed within 72 hours after dental Hygiene. narked other than "natural", or	Completed	15. Decedent's Education (Spec Elementary/Secondary (0-12)		1-4 or 5+)	during	most of wo	orking life. D Mechai	O NOT u				erona			
ID 21215-0036 : should be filed within 7 and Mental Hygiene. ?7 is marked other than matic event, the Medica	Be	17. Father's Name (First, Middle, Guy R. Hinegar	dner, Sr.				1	Haze:	1 Hug						
MD 21  Id 2 should  lith and Me  m 27 is ma	To	19a. Informant's Name/Relations Virginia Carri			19b. Maili 3712	ng Addres 8th	s (Street a Avenu	e, E	er or Rura dgewa	ai Route N ater,	Mary	land	210	37	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er		20a. Method of Disposition  1 Burial 2 X Cremation  4 Donation 5 Other Sp.  21. Signature of Funeral Seviles	ecify:	rom State	Place of Disportermatory or Cas Cro	other place emato	ry	(	07/20		1 Edg	gewat	er,	own, State Maryland	
		2973 Solomons Island Road, Edgewater [33a. Part]. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart													al
Physician /Medical ≛xaminer		Immediate Cause (Final disease or complications that caused the death. Do not enter the mode or dying, such as calculate or respiratory ariest, shock of heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):												Between Onset an Death	
	_	Sequentially list conditions, if any, leading to immediate	b	a consequence o					<del></del>						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of								_		<u>.</u>	_
e executed sian and sial - transi	_ (	UNPENDED	d. AMENDED	10c pe:	r fh g	918 8	3-8-11	vt							_
Division of Vital Records, P.O. Box 68760, To the Etopital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unk	1 Live b	nant at time of de	2 F	Fetal death Other (Spe	_	Ectopic p	pregnancy	,	230	d. Date of o	delivery D	ay Year	
P.O. Bo:		Part II. Other significant conditi	ons contributing to	own o death but not re	esulting in the	underlyin	g cause give	en in Part	t I.					ne cause of death?	_
ords, P.C. w requires that as been signed I should be deta	Completed by		-							24a. Wa		pı	/ere aut	opsy findings availab impletion of cause of	le
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Vita hysicia this ce	To Be	examiner? 1 <b>✓</b> Yes 2 No		Inpatient 2	ER/Outpatie				Nursing I			nce 6 🗸		Scene	
Division of Vital Records, talor Attending Physician: The law requirers after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be a page 2.		27. Manner of Death  1 Natural 5 Pend 2 Accident Inves	ling 28a. Date Jul 17, 2	of Injury 1. Day,Yaar) 2011	28b. Time o 0810 hrs	f Injury	28c. Injury	at Work? s 2 ✔ N	IDr	d. Describ iver auto			d		
Divisipital or Attours after dours after dinectal Direct filled in by	Certification:	3 Suicide 6 Could	d not be 28e. Plac	Major Road			y, office buil	lding, etc.		f. Location or Town st Route				al Route Number, Cit City, Md.	y
To the Hosp within 24 ho To the Rune completely fi	Medical C		nysician: To the bearing miner:On the basis and manner s	of examination a											
	Me	29b, Signature and title of certifie				29	O.C.M.					Date signe		h, Day, Year)	
10+1		30. Name and address of person Ana Rubio MD. Ass	who completed cau istant Medical			ltimore	Street, B	altimore	e, MD 2	1223	- 1			-	
St	ate	31. Date filed (Month) Pay, Y3an	2011 32. B	gistrar's Signatu	ire /	a Kar	,		_						_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) Physician/ 01 Diane Anita Jefferson-Lopez Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctors Community Hospital Prince George's Lanham Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number . Age (In vrs. last birthday **Funeral** Countr Wash. Days Hours 1 M 2 X Months 07/01/1949 62 .D.C Director 579-66-3828 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at Director 1 🖵 Yes 2 🗌 No Md. Prince George's Beltsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a Funeral 11306 Clearbrooke Court 20705 U.S.A. items 2 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2X No Black, White, etc. ō 1 Never Married 2 Married ş altimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: Black If Yes, Give "natural", Completed 3 ₩ Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Family Services 12th <u> Administrative Ass't.-PG Co</u> other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Clarence Lewis Hattie Womack Page 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David J.F. Michals, Jr. / Son 11306 Clearbrooke Ct., Beltsville, Maryland 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/30/11 Clinton, Maryland Resurrection Cem 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc. Signature of Funeral Service Licensee Marry 1. Cratt 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20010 Approximate Interval Between Onset and Death Immediate Cause (Final HEMORRHAGE Physician/ ECURRENT disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner AGULOPATH Eequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of STAGE use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death signed by the a ☐ Yes ∠ 
☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SPIRATORY 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an POTENSION prior to completion of cause of death? cate has page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be 1 ☐ Yes 2 ☐ No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending 24 hours after death. Funeral Director: Af 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 01-24-2011 npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

11-04949 Linda D. Kaifes Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

inda D. Kaifes		State of Maryland - For State tegistrar		artment o rtificate o			Menta		Reg.	201 <sub>No.</sub>			
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Linda D. K	aifes					2. Date of Month		ay Year	3. Time of Death 1350 hrs		
		4a. Facility Name (if not institution, give street and number 1324 Shore Drive				Town, or Lo	ocation of [		,	4c. County of Death Anne Arundel			
Funeral Director		5. Social Security Number 6. Sex 7. Ag 219-64-7681 1 M 2 X F 56		ast birthday) Y	If Und Month	er 1 Year ns Days	If Under 2 Hours	Min	of Birth(N	MM/DD/YYYY) 9. Bir Foreig Co			
апу	ļ	Usual Residence of Decedent  10a, State 10b, County	10c. City.	Town or Loc	ation						10d. Inside City Limits		
<b>A</b> .11	5	Maryland Anne Arundel		ewater						_ =	1 Yes 2 No		
eath with the Maryland ritems 23a or 28a-f show ust be notified at once.	Director	10e Street and Number 1324 Shore Drive			10f. Zip	0 Code 037			10g.	Citizen of What Coul USA	ntry?		
	ē				Yes, speci		Mexican, P	? ( Specify Yes uerto Rican, ef		14. Race - Ameri White, etc.	can Indian, Black,		
ours afte	d b	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade con	mpleted)		ent's Usual	Occupatio	n (Give kin	nd of work done	16	Specify. WITE			
215-0036 e filed within 72 hours after of lal Hygiene. ked other than "natural", on nt; the Medical Examiner	mplete	Elementary/Secondary (0-12) College (1-4 or 2	5+)	House	most of wo wife				- 1	Own Home			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be Co	17. Father's Name (First, Middle, Last) William C. Nolte						Name (First, M .a Kay					
D 2121( should be fill and Mental H 7 is marked natic event, i	၉	19a. Informant's Name/Relationship (Type, Print )		- 1	_	•				r, City or Town, State			
e, MD 1 and 2 sho Health and item 27 is	ŀ	Karl J. Kaifes/Husband		Place of Disp crematory or	osition (Na	me of ceme		Date	2	1e, MD 21 Oc. Location - City or	Town, State		
Baltimore, MD 2 permit. Pages I and 2 shou. Department of Health and N Important: If item 27 is n injury or other traumatic		1 Burial 2 X Cremation 3 Removal from S 4 Donation 5 Other Specify:	ale	las Cr	emato:	ry		/20/20		Edgewater			
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat	22. Name and Address of Facility George P. Ka. 2973 Solomons Island Rd. Edg										gewater, MD 21037		
Physician	1	234 Part I. Enter the disease, or complications that caused failure. List only one cause of each line.	the death	. Do not ente	r the mode	of dying, s	uch as card	diac or respirat	ory arrest,	, shock, or heart	Approximate Interval Between Onset and Death		
Examiner	İ	Immediate Cause (Final disease or condition resulting in death)  a. Smoke Inhalati			ij <b>urie</b> s						Dean		
	, i	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons	equence o	of):					_				
	edical Examiner	causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a cons	equence o	of):									
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760, cate be e physicia he buria		IF FEMALE: 23c. If yes, outco	me of preg	nancy						23d. Date of deliver			
Box 6876( c death certificate the attending phy ed for use as the b	Physician/N	23b. Was decedent pregnant in the past 12 months?  1	t time of de	noth	Fetal death Other (S <i>p</i> e	_	_Ectopic p	pregnancy		Month I	Day Year		
that the des		Part II. Other significant conditions contributing to dea	th but not r	esulting in the	e underlyin	g cause giv	en in Part	"  -		cco use contribute to			
IS, P.O. quires that then signed by all be detach	1 Yes 2 No 3 P  24a. Was an 24b. Were									oably 4 Unknown			
e law requir	Completed								autopsy performe Yes 2	prior to death?	completion of cause of		
Vital Rec ysician: The his certificate director, page	Be Co	25. Was case referred to medical examiner?						heck only one					
of Vit. Physici er this c	은	examiner? 1  Yes 2 No Hospital: 1 Inpati 27. Manner of Death 28a. Date of Inj	ent 2	ER/Outpatie		DOA C		Nursing Home 28d. De		esidence 6 🗸 Othe	r: Scene		
ion of very tending Pheath.  tor: After til the funeral	ation	1 Natural 5 Pending Jul 2, 2011	Year)	0000 hrs		1 Yes 2 ✓ No							
Division of Vital Records, pital or Attending Physician: The law requirement after death.  reral Director: After this certificate has been sifiled in by the functal director, page 2 should the control of the control	Certification:	3 Suicide 6 Could not be determined (Specify) Si				y, office bu	ilding, etc.	or T	cation (Street and Number or Rural Route Number, Cit Town, State) hore Drive, Edgewater, MD				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a. Certifier 1 Certifying Physician: To the best of rone)  2 Medical Examiner: On the basis of examiner:	amination a										
C3	₩	29b. Signature and title of certifier			29	c. License				29d. Date signed (Mo	nth, Day, Year)		
5		Panich Visit Policy MAS  30. Name and address of person who completed cause of	death (Iten	n 23a)		O.C.N	1.E.			July 3, 2011			
		Pamela E. Southall, MD Assistant Med	lical Exa	miner 9			Street,	Baltimore, I	MD 212	223			
St Regis	tate	31. Date filed (Month Cay, 2a) 2011 32. Figistr	ar's Signat	ure .	are								

State of Maryland / Department of Health and Mental Hygiene 20 かかつ State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, Month Day Physician/ INGE BETTY LYONS 10:44AM JULY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SHADY GROVE HOSPITAL ROCKVILLE MONTGOMERY 201 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. (Month, Day, 1 M 2 X 216-52-1429 Yrs. Director 80 AUG. 1930 GERMANY 7 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director Tuch MD. MONTGOMERY ROCKVILLE 1 X Yes 2 No 28a-f 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 'n must be Completed by Funeral 23a 9701- VEIRS DRIVE 20850 USA ral", or items ? Examiner mus death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2X No Yes, Give 72 hours after 21215-0036 1 ☐ Yes 2X☐ No Specify: Specify.WHTTE 3 

Widowed 4 □ Divorced "natural" Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur lury or other traumatic event, the Medical I lury or other traumatic event, the Medical I Decedent's Education 16a, Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER AT HOME Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARTIN GERNET ELISE GERNET 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, REV.DR.REICHARD- PER.REP. 13701 GLEN MILL RD., ROCKVILLE, MD. 20850 20b. Place of Disposition (Name of cemetery, crematory or other place 20a Method of Disposition 20c. Location - City or Town, State permit, Page 1
Department of I
Important: If it
any injury or of X□ Burial 2 □ Cremation 3 □ Removal from State ARLINGTON NAT.CEM 9/21/2011 ARLINGTON, VA. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 2222-WISCONSIN AVE., NW Signature of Funeral Service License Will HYSONG CO. WASHINGTON, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Tallyre Ph, sician/ egrivator disease or condition resulting in death) Medical Due to ( as a consequence of): Examiner e thus ion louval bilateva Sequer tielly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) bacteremia taphy lococco burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical disease Stage renal end Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy ρ Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 1 ☐ Yes ∠ a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\subseteq\) Nursing Home 5 \(\supseteq\) Residence 6 \(\supseteq\) Other (Specify) မ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation after deatl Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de

To the Funeral Directo
completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and title of certify MD DO067380 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) center Drive, Rockville, Maryland MD 9901 Medica John, 31. Date filed (Month, Day, Ye JUL 2 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician/ 5:30 AM Jay Arthur Lane, Jr. 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** General Montgomer Montgomer Olne If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Social Security Number **Funeral** Oct. 6, 1952 Country 1and Months Days Hours 215-58-7964 58 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Howard Woodbine 10g. Citizen of What Country? 10e. Street and Number Funeral USA 3513 Hipsley Mill Rd. 21797 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces2
1 ☐ Yes 2 7 No Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) County Government Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlotte Merola Lane Jay A. Lane, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25266 Conrad Court, Damascus, MD 20872 Shelley M. Carow, Sister Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)
Poplar
Springs Cemetery 1 & Burial 2 Cremation 3 Removal from State 07/22/2011 Mount Airy, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Eachly Molesworth—Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, MD 20872 21. Signature of Funeral Service Like Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on complications that shock is the shock of the shock aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Emysician/ disease or condition Medical resulting in death) Due to (or as a consequ **Examiner** Sequentially list conditions, If any leading to immedicause. Enter Underlying Cause (Disease or linjury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequenc resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months? Pregnant at time of death 1 Yes 2 No s been signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 No s certificate has be lirector, page 2 s 1 Yes 2 No 26. Place of Death (Check only one) funeral director. 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) npatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work' 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident Investigation 24 hours after deatl pleted filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29d. Date signed (Month, Day, Year) 29c. License number 18/2011 D00 71314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Philip Dr. OLney mo 20837 MD istrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Lou Llewellyn Manth 800 M Physician/ Mary Medical 4b. City, Town, or Location of Death Cumberland 4a. Facility Name (if not institution, give street and number) 4c. County of Death Allegany Examiner WM. Regional Medical Center Age (In yrs. last birthday) 5. Social Security Number 220–30–7983 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F June 7 1933 Maryland **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show sdical Examiner must be notified at 10d, Inside City Limits filed within 72 hours after death with the Maryland tal Hyglene. die Hyglene de her than "natural", or items 23a or 28a-f shoo event, the Medical Examiner must be notified at event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State Director Lonaconing MD Allegany 1 XYes 2 No 10f. Zip Code 21539 10g. Citizen of What Country? 17308 Engine House Row Road Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married white Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Housework Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the A once. Homemaker unknown Be 18. Mother's Name (First, Middle, Maiden Surname)
Charlotte Shockey 17. Father's Name (First, Middle, Last, William Gardner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17308 Engine House Row Road, Lonaconing, MD 21539 19a. Informant's Name/Relationship (Type, Print)
Sylvan Llewellyn/husband Baltimore, 20c. Location - City or Town, State Cumberland, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 07/24/2011 cemetery, crematory or other place)
Cumberland Crematory 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licenses 111 Church St, Westernport, Maryland 21562 7. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Approximate nterval Between Immediate Cause (Final PARDIOGENIC Physician/ disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 3 Probably 4 Unknown 1 🗌 Yes Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform has page 2 1 ☐ Yes 2 ☐ No this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 Department 2 ER/Outpatient 3 DOA မ 28a Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Deat 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injurv Matural 5 Pending Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ only one) 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year, JUL 2 5 2011

Nam

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. William Lamm, 12500 Willowbrook Road, Cumberland, MD

am ms

2011

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per Phy C918 8/19/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) Anita 2. Date of Death July Physician/ 5:00 Catherine Annette Lucas Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick 4738 Fox Tower Rd. Smithsburg 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours 1 M 2 TF 94 219-20-4380 Maruland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b County 10c. City, Town or Location 10a. State Director 1 Yes 2 No Smithsburg Maryland Frederick 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21783 4738 Fox Tower Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ş Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Clothing Seamstress Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rae Toms Ora Willard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4738 Fox Tower Road Smithsburg, Maryland 21783 (Son) Paul E. Lucas, Sr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) August Foxville, Maryland Browns Cemetery 2011 21. Signature of Funeral Service License J.L. Davis Funeral Home 22. Name and Address of Facility 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to or as a consequence of) **Examiner** sclarosis Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregna
☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death detached 9 Unknown **To the Funeral Director:** After this certificate has been signed by 'completed filled in by the funeral director, page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 34Vo 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smiths burn MD State

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Marylar	nd / Depa <i>Cer</i>	artment of H tificate of L	Health and N Death	Mental Hyg	giene Reg. No. 20		25194
	Dhusisis	- /	Decedent's Name (First, Middle,	Last)	-				2. Date of Dea	th	,,	3. Time of Death
	Physicia Medic				Wilson_	Luff			July	31 2	2011	_0045 A™
	Examin	er	4a. Facility Name (if not institution,	give street and nur	nber)			Location of Death		4c. County		
	Funeral		Sunny Acres 5. Social Security Number	3. Sex	7. Age (In yrs. i	ast birthday)	North If Under 1 Year	Last If Under 24 Hrs.	8. Date of Birth		Cil 9, Birthpl	ace (State or Foreign
	Director		218-32-2034	1 [X] M 2 □ F	75	Yrs.	Months Days	Hours Min.	May 17	1936	Penns	y) sylvania
-	nd how at	ŗ	Usual Residence of Decedent  10a. State 10b. County		10c, Cit	ty, Town or Loc	cation				10	d. Inside City Limits
	// Aaryla 8a-f s tiffied	Director	Maryland Cec	i1		North E						1 ☐ Yes 2 ☐ No
	a or 2 be no	I Dii	10e. Street and Number		1	NOI CII I	10f. Zip Code			10g. Citizen of	What Count	
	th with ns 23 must	Funeral	33 Dr. Carr Roa				21901			Unit	ed Sta	ites
_	r deal or iter	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marrie</li></ul>	Armed Fo	edent Ever in U.:		Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Spanic Origin?) n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America ck, White, et	
215-0036	rs afte Iral", Exan		3 Widowed 4 X Divorced	If Yes, Giv Year or Da	/e	1	☐ Yes 2 🙀 No	Specify:		Specify	. Whi	te
2	2 hou "natu edical	Completed	15. Decedent (Specify only highes		)	16a. Deced	ent's Usual Occup	ation funing most of work	ina	16b. Kind of B		
7	ithin 7 ene. r than	Com	Elementary/Seconday (0-12)	College (1		life. DO	NOT use retired)	ed Repair		Tele	visio	n Repair
ב מ	iled w if Hygi other	Be	17. Father's Name (First, Middle, La	st)		1 561	- Cmproy	18. Mother's Nam				пкеран
ylar	ld be 1 Menta arked atic e	မ	Unknown					Unkn	own			
maryland	shound and 7 is m		19a. Informant's Name/Relationship					and Number or Rura				ode)
e)	and 2 Healtl tem 2:		David H. Rash/C	lergy	205 5		unt Valle sition (Name of	y Court,			1921	State .
baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp	Removal from	State	emetery, crem	istory or other plac is & Co., I	e) Augu	st 1,	20c. Location	-	ster, PA
	mit. P partm portal y injur		21. Signature of Funeral Service Lice					ss of Facility Hi	cks Home			
מ	89 = 88		- Omned.	8. Hic	ho			Stockton				21921
	cate be executed  Medical physician and sthe burial-transit	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):										
3	ate be	edical		d								
. DOX 001	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours are death.  Within 24 hours are death.  To the Funeral Director After this certificate has been signed by the attending is completed filled. By the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 🔲 Live	nant at time of o	aldeath 3 🗌	Ectopic pregnanc Other (specify)	у			ite of deliver	<b>y</b> Day Year
5	s that t gned b	þ	Part II. Other significant condition	s contributing to d		1			23e. Did tob	pacco use cont		cause of death?
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220	Attending Physician: The law rer decth.  ector After this certificate has by the funeral director, page 2 sl	Completed	huner to soon	by, per	ophera	Vasi	Culor 0	isease,	24a. Was ar autops perform 1 \(\sum \) Yes	SV	Were autops prior to com death? 1  Yes 2	sy findings available pletion of cause of
9	sician; certifi rector	00	25. a case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:			Othe	ce of Death (Check		* *		
5	y Phys er this eral di	e: 10	27. Manner of Death	28a. Date	Inpatient 2  of injury	28b. Time of	3 DOA 28c. Injury	4 □ Nursing Ho	me 5 Reside			assisted living
5	ending seth. ir Afte	licat	1 X Natural 5 ☐ Pending 2 ☐ Accident ☐ Investiga	tion	th, Day, Year)	i <b>n</b> jury	M 1 🗆	? Yes 2 ☐ No		,.,		
2	or Atta a erde Directo by t	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place	of Injury - At hong, etc. (Specify		et, factory, office		28f. Location (Str City or Town		er or Rural F	Route Number,
ָנ	To the Hospital or Attendia within 24 hours are det.th.  To the Funeral Director All  completed filled by the fu	Medical	(Check 2 L Medical Exa	aminer: On the bas	is of examination	n and/or investi	gation, in my opinio	date and place, an n, death occurred at time, date and place	the time, date and	d place, and du	e to the caus	e(s) and manner stated.
	Not with Con		29b. Signature and title of certifier	7 _			29c. License			9d. Date signe		
			Ma	Y 4 M	<u>n</u>		0003	9334		Augusi	10,0	2011
			30. Name and address of person when the Perking of the perking of the person with the person of the	MD 3	e of death (Item 19 E.	23a) (Type, Pr Pulask	int) Hay	Elki	ton, s	100	1921	
	State Registra		31. Date filed (Month, ⊅ex, ¥ea	2011 32. R	Signat	B. 4	ald		·			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 1630 DUSar 2011 JUly oan 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Cambridge Dorchester Hospital orchester reneral Birthplace (State or Foreign Country) If Under 1 Year | If Under 8. Date of Birth (Month, Day, 5. Social Security Number (In yrs. last birthday) 1□ M 2 🖫 F Hours 16-48-5739 April Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Ves 2 No Mbrid 10g. Citizen of What Country? 10e. Street and Number 2161 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) le v k 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) #4 20b. Place of Disposition (Name of cemetery, crematory or other place)
M. d. Shore Crematory armelit 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Colleen Curran Bromwell, PA.

22. Name and Address of Facility
Henry Funeral Home,
510 Washington St. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause or each line. as cardiac or respiratory arrest,

**Physician** /Medical **Examiner** 

the attending physician and hed for use as the burial-trar

signed by to be a detach

has

certificate

After this

within 24 hours after death.

To the Funeral Director: A

sompletely filled in by the funeral director, page 2 should

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Funeral Director

Be Completed by

2

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: fritem 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at once.

Examiner Physician/Medical þ

Be Completed Certification: To

Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of)  d	e Hert ic Colde Renel D	omyop	othy _
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic; 4  Pregnant at time of death 5 Other (s)			3d. Date of delivery Month Day Year
	ontributing to death but not resulting in the underlying o	cause given in Part I.		se contribute to the cause of death?
			24a. Was an autopsy performed? 1 □ Yes 2 ▼No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ▼No
25. Was case referred to medical		26. Place of Death	(Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ D	OA Other: 4 Nursing Ho	me 5 ☐ Residence €	G ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury		28d. Describe how injury	y occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	y, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number, )
29a. Certifier 1 Certifying Phy	ysician: To the best of my knowledge, death occurre	d at the time, date and place,	and due to the cause(s)	) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Medical

29b. Signature and title of certifier

30. Name and address of person who

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day July Physician/ Yvonne Agnes Mahoney 2011 9:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2725 Vivians Wav Calvert St. Leonard . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 1 M 2 TF 14729/1919 91 029-05-8334 New Hampshire Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Maryland Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2725 Vivians Wav 20685 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc Yes 2 X No Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 XWidowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Teacher Education permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, ? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Gonthier Alma Sevigny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary McKeon / Daughter 2725 Vivians Way, St. Leonard, Maryland 20685 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Olivet Cemetery 07/27/2011 Washington, D.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, PA. Kyle S. Simons MO1200/ 4405 Broomes Island Road Port Republic, Maryland 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ CONGESTIVE disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? detached for Month Year Day Pregnant at time of death 9 Unknown g 🗌 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 74 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 5 - Pending 1 Natural 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JRW

State

Registrar

31. Date filed (Month, Day, Year)

JUL 22 2011

32. Registrar's

HOSPITAL Rd. HEINCE FREDERICK MIN 2068

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar		artment of He tificate of De			Reg. No.	25197
	Physicia Medic		Decedent's Name (First, Middle, Lass  Willie Mae	,				2. Date of Dea Month July 2	21, Day 2011 Year	3. Time of Death 3:55 A M
A	Examin		4a. Facility Name (if not institution, give 10671 Finn Dr	,		4b. City, Town, or L	ocation of Death		4c. County of Dea Frede	
	Funeral Director		Social Security Number 6. Se		last birthday) Yrs.	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug. 30	9. Bin Year 1925 Nor	thplace (State or Foreign
	land show d at	tor	Usual Residence of Decedent  10a. State  10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
	e Mary r 28a-1 notifie	Director	Maryland Freder	ick	Ne	ew Market				1 🗆 Yes 🚈 No
	with the	Funeral I	10671 Finn Dr	ive			774		10g. Citizen of What Country Unite	d States
36	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Wildowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1	Was Decedent of Hisp f Yes, specify Cuban, I ☐ Yes 2 🋣 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	2 hours "natura	Completed	15. Decedent's Ed (Specify only highest gra	lucation		dent's Usual Occupati kind of work done dui		ing	16b. Kind of Business	· · · · · · · · · · · · · · · · · · ·
2121	vithin 7 giene. er than the Me		Elementary/Seconday (0-12)	College (1-4 or 5+)		O NOT use retired) emaker			Own H	ome
Maryland 2	should be filed within 7: and Mental Hygiene. is marked other than aumatic event, the Me	To Be	17. Father's Name (First, Middle, Last)		•			e (First, Middle, I	Maiden Surname)	
aryk	nould b nd Mei s mark umatic		Owen Smith  19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street an			; City or Town, State, Z	ip Code)
	and 2 st Health a tem 27 is		Deborah Heilman			l Finn Dr.				
Baltimore,	. Page trnent o <b>tant: If</b> jury or		20a. Method of Disposition  1 ☐ Burial 2 🏋 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State  state	cemetery, cren	sition (Name of natory or other place) Crematory	1 7 400			, Maryland
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licens	Stanley		2. Name and Address $621$ Opossu	,		er Funeral derick, MD	
	Physician/ Medical Examiner	er	23a. Part 1. Enter the disease, or compshock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a.  Due to ( r a. a consecto)  Due to ( use a consecto)	quence of):	er the mode of dying,		or respiratory arr	est,	Approximate Interval Between Onset and Death
092	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last							
. Box 687	he death certific y the attending I ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	23c. If yes, outcome of pregn 1  Live Birth 2  Fe 4  Pregnant at time of 9  Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
rds, P.O.	equires that t een signed b nould be deta	Completed by P	Part II. Other significant conditions co	entributing to death but not re	esulting in the u	inderlying cause give	n in Part I.	1 🕪		Probably 4 Unknown
Division of Vital Records,	r: The law r icate has b r, page 2 sh					<i>V</i>		1 🗌 Yes	osy prior to rmed? death?	utopsy findings available completion of cause of
Vital	ysician s certif director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	BR/Qutpatier	Other	e of Death (Check		lence 6 🗆 Other (Spe	cifv)
on of	nding Ph ath. : After thi e funeral	Certificate: 7	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury a work?			ow injury occurred	
Division	al or Atte s after de il Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif	nome, farm, str	eet, factory, office		28f, Location (S City or Tow	itreet and Number or Ri n, State)	ural Route Number,
_	he Hospit in 24 houn he Funera pleted fille	Medical	(Check 2 Medical Exami	ician: To the best of my knowner: On the basis of examination of the best of notes to the best of notes.	on and/or invest	tigation, in my opinion,	, death occurred a	t the time, date a	nd place, and due to the	cause(s) and manner stated.
	To t with To t		29b. Signature and title of certifier	Marian	11	29c. Liçense r	0395	-	29d. Date signed (Mon	th, Day, Year)
	;		30. Name and address of person who cowilliam Conve	ompleted cause of grath (Item	m 23a) (Type, F	Print) Frederick	, MD 217	02	July	
	Sta	te	31. Date filed (Month, Day, Year)	20 De jotraria Cian	otuvo		-			-
	Registra	ar	JUL 222	UII Jeneur	A. A	Backer				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 25198 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2011  $\mathtt{July}^{\mathtt{Month}}$ 15 8:00a Gordon Lee Miltenberger 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Lorien Mt. Airy Airy 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Ohio 1 🛛 M 2 🗆 F Days Hours T926 276-22-6768 85 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 K Yes 2 □ No Mt. Airy Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 705 Merry Go Round Way 21771 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☒ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates. WWII Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Commissary Officer U. S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dewey R. Miltenberger Katherine Coss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 Merry Go Round Way Mt. Airy, MD 21771 Dolores Miltenberger/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery July 19,2011 Mt. Airy, Maryland. 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown 21. Signature of uneral Service I Prederick, Maryland 21702 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Physician/ Medical Examiner

Physician/

Medical

10a. State

Director

Funeral

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Completed

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Examiner

**Funeral** 

Director

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within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

and Mental Hygiene. is marked other than

permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event,

Baltimore, Maryland 21215-0036

sician and burial-transit for the ned signed by t d be detach his certificate has b il director, page 2 sl this funeral ithin 24 hours after death.

the Funeral Director: After ormpleted filled in by the fun

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Immediate Cause (Final disease or condition resulting in death)	a. One est victor as a consequence of):	+ failure			Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due I) (or as a consequence of):  c. Due to (or as a consequence of):  d.				10 years
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 N No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of del Month	livery Day Year
Part II. Other significant conditions	contributing to death but not resulting in the und	derlying cause given in Part I.			the cause of death?
			24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
25. Was case referred to medical		26. Place of Death (Che	ck only one)		
examiner? 1 Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing F	Home 5 ☐ Residence	6 Other (Spec	d Living Acilit
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigat		28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		t, factory, office	28f. Location (Street a City or Town, Sta		ral Route Number,
(Check 2 Medical Exa	nysician: To the best of my knowledge, death oc miner: On the basis of examination and/or investig urse Practioner: To the best of my knowledge, de	ation, in my opinion, death occurred	at the time, date and pla	ce, and due to the	cause(s) and manner stated
29b. Signature and title of certifier	led comp	29c. License number R(18354	29d. [	Date signed (Month	n, Day, Year)

MD 31122

State Registrar

15

gistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amy Shule CLUP 7900 (In K. Anin +

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DOLORES VIRGINIA MOTICHKA 2011 JULY 6:08 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CENTREVILLE QUEEN ANNE'S QUEEN ANNE'S COUNTY HOSPICE CENTER Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 6. Sex **Funeral** (Month, Day, Days Hours 1 M 2 X F 217-30-7907 MARYLAND Director 1936 75 JAN. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗋 Yes 2 🗌 No **PINELLAS LARGO** FT. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 ULMERTON ROAD, LOT#942 33771 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 SECRETARY HEALTH CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARY LOUISE HESSEY BERNARD FRANKLIN DADDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNARD W. MOTICHKA/ HUSBAND 100 ULMERTON RD,LOT #942, LARGO, FL 33771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State JULY <sup>D</sup>26. 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, ST. PETER'S CEMETERY QUEENSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 23a. Part 1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final BRAIN Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of,: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Records, 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? RACT CANCER 24a. Was an performed? 1 Yes 2 We No Yes 2 WN Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? HOSPICE CENTER
4 Nursing Home 5 Residence 6 Other (Specify) Other: 2 ANO မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nicaed cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete CIGANEK, M.D., 629 RAILROAD AVENUE, CENTREVILLE, MD 21617

DHMH 17 Rev 7/2009

State

Registrar

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 2011 MARY TUCKER MULLIKIN IILY 19 8:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S CENTREVILLE 730 HOPE ROAD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min. (Month, Day, Year) JAN, 27, 1922 1 🗆 M 2 🕱 F MARYLAND Director 218-16-8616 89 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10a, State 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director QUEEN ANNE'S CENTREVILLE MD 1 Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21617 730 HOPE ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, "natural", or iter edical Examiner Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: Completed 3 ₩ Widowed 4 □ Divorced WHITE Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER -0-Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARY TUCKER SUTTON ARTHUR MORGAN LUSBY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH A. MULLIKIN/ SON t. Page 1 and 2 s tment of Health a 200 MULLIKIN LANE, CENTREVILLE, MD 21617 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) JULY 23, CHESTERFIELD CEMETERY CENTREVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician CONGESTIVE HEART FAILURE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events ATRIAL FIBRILLATION and the burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 SS IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) jo in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 X No g Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown AORTIC STENOSIS 24b. Were autopsy findings available prior to completion of cause of 24a. Was an HYPERCHOLESTEROLEMIA autopo performed: 2 No page death? 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 **X** No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/20/2011 D35048 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 629 RAILROAD AVENUE, CENTREVILLE, MD 21617 ERIC F. CIGANEK, M.D.,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

Day, Year)

32 Registrar's Signature

11-05738 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mary Elizabeth Mical State of Maryland / Department of Health and Mental Hygiene 2011 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day July 31, 2011 MARY ELIZABETH MICAL **Medical Examiner** 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Chester River Hospital Center Kent Chestertown 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Min. oreign Sept 27, 1943 Director 222-26-1831 2X F 67 Country) 1 M Usual Residence of Decedent 10c. City. Town or Location 10a State 10b County imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. DE New Castle Wilmington Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19803 U.S.A. 1318 Oberlin Rd. Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specity Yes or No 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes White 3 Widowed Give Year 1 Yes 2 X No specify: Specify 4 Divorced ě or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Social Services 5+ Director 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Elizabeth Wordell Joseph Billingsley, Sr. Be ဥ 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1318 Oberlin Rd. Wilmington, DE. 19803 Richard Mical (husband) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, timore, Department of He Important: If its injury or other t crematory or other place; 1 Burial 2 Cremation 3 Removal from State 8/5/11 Wilmington, DE. Century Crematory Denation 5 Other Specific 22. Name and Address of Facility
Donerty Funeral Homes are of Fune M00510 3200 Limestone Rd. Wilmington, DE. 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failurg. List only one cause on each line /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Division of Vital Records, P.O. Box 68760, and ratending Physician: The law-requires that the death certificate be executed Physician/Medical After this certificate has been signed by the attending physician : funeral director, page 2 should be detached for use as the burial -UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 ✓ No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? Yes 2 ✔ No Yes 1 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA 1 V Yes 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pendina filled in by the

25201

1458 hrs

10d. Inside City Limits

1 Yes 2 X No

Approximate Interval

Between Onset and

Death

Year

2 No

Day

Nursing Home 5 Residence 6 Other 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Homicide 29a. Certifier (Check only 1 one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: 9 the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 2, 2011 completed cause of death (Item 23a) 30. Name and add Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

**OCME** 

Mary G. Ripple MD 31. Date filed (Moi State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Una Morton July 30, 12;45 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Wicomico 6369 Whitecove Drive Salisbury Social Security Number 6. Sex 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Tennessee 1 □ M 2 🗓 F Months Hours Month, Day, real, / 30/1905 **Director** 105 <u>409-26-3080</u> Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 XNo Salisbury Maryland Wicomico 5 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral United States 21801 6369 White Cove Drive death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Salesperson permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, : Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rose (Unknown) Cal Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Fuson/Granddaughter 6369 White Cove Drive, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Frederick, Maryland 08/03/2011 Mt. Olivet Cemetery Funeral Service License Keeney and Bastord PA Funeral Home 106 East Church Street, Frederick, MD 21701 23a. Page . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subsete \text{ No} \) Month Day Year Pregnant at time of death signed by the ε Id be detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy certificate Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) After thi funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes Natural Certificate: injury 5 Pending 2 No Accident Investigation within 24 hours after death To the Funeral Director: / completed filled in by the i 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

DHMH 17 Rev 7/2009

only one)

OUR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25203 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Medvedeff Physician/ Month 201 200 PM Harold Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Battimore Maryland University 0+ 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □**X**M 2 □ F Months Hours April Day Year) 1918 China **Director** 702-01-3051 93 Usual Residence of Decedent or 28a-f show notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 🎦 No MD Odenton Anne Arundel 10e. Street and Number 10f. Zip Code P 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 21113 USA 498 Cathy Ct. within 72 hours after death 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian was Decedent Ever in U.S Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates. 41-66 Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Airforce Col. and Mental Hygien is marked other t Be UNK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ilia Michaelovich Medvedeff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 498 Cathy Ct. Odenton, MD 21113 E. Rebecca Medvedeff (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Crownsville Vet. Cem. 7/19/2011 Crownsville, MD 21. Signature of Funeral Servicensee 22. Name and Address of Facility Hardesty Funeral Home 851 Annapolis Rd. Gambrills, MD 21054 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Abdominal Aurtic Aneurysm disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) that the death certificate be executed the burial-transi Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2-No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 🗌 No Yes the Hospital or Attending Physician: the funeral director, Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \( \text{Yes} \) 2 \( \text{No} \) 1-Natural iniury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 1699900878 201)

Registrar
DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

park

Registrar's Signature

22 South Greene Street Baltimore MD ZIZOI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hoover

-essica

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7 Merrill Physician/ 12-39PM Medical 43-Facility Name (if not institution, give street and number Conference of as to a Conference of a Conference 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stilvna Para true Arunde If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 01, 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday 1 XM 2 🗆 F 99 Hours 224-52-6366 California **Director** Usual Residence of Decedent 28a-f shov 10a, State 10c. City, Town or Location 10b. County with the Maryland 10d. Inside City Limits Director items 23a or 28a-f s her must be notified Anne Arundel Severna Park MD 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 USA 3 Triple Oak Lane permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1929 1 Yes 2 No 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ U.S. Navy Captain Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Elizabeth Hatch Grayson Merrill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Triple Oak Lane Severna Park, MD 21146 Jane Merrill / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State July 16, 2011 Baltimore, MD Metro Crematory, INC. 4 Donation 5 Other (Specify) . Signature of Euneral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enterthe etsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition MKUOWN Medical resulting in death) Due to (or as a consequence of) Renal Failure Examiner nunic MICHUM Sequentially list conditions, Examine il any hading to immedicause. Enter Underlying Cause (Disease or iinjury toa Unkrowv burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in by the funeral director, page 2 should be detached for use as the burn. P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Day Pregnant at time of death g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No injury 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To 29d. Date signed (Month. Day, Year)

State Registrar

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Drive #1A Annapoles, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007 Tidewater Colony

31. Date filed (Month

JUL 2 0 2011

FG1389

Jennifer H Clarkings

110111

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death , Day 2011 Mabel Morris Physician/ Lena July 16, 6:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CAROLINE HOMESTEAD MANOR ASSISTED DENTON LIVING If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Months Days 0470571923 214-30-8452 Maryland **Director** 88 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No Maryland Caroline Denton 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral USA 21629 410 Colonial Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dora E. Gordy Jason Asbury Morris Jr. Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print)

Margaret Peters/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 356 College Blvd., Kutztown, PA 19530 20b. Place of Disposition (Name of cemetery, crematory or other place Wicomico Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 7/21/2011 Salisbury, MD 4 Donation 5 Other (Specify) Signalury of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ end Stan dementic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence A 35.57ed 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2  $\square$  No 1 Tes Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatore and title of certifier 29c. License number 0005 325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Welmade Butter 3683 Ch Proton 82 Welin 31. Date filed (Month, Day, Year)

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State Registrar gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State 25206 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7 GNOM YA. POOLE 1738 5 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BATIME OF MARYLAND MRIS CENTER If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Min 84 **Director** 08/02/1926 226-36-4223 Usual Residence of or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MONTGOMERY 1 Yes 2 No POOLESVILLE MD 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 16315 OLD RIVER ROAD 20837 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or iten I Examiner r 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: "natural" 3 Widowed 4 Divorced WHITE Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) If Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the STORE OWNER RETAIL 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be filed it of Health and Mental Hi If item 27 is marked otl or other traumatic even ၉ JOHN ETHAN POOLE SARAH ANNA BEALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARILYN POOLE / DAUGHTER 14405 PARTNERSHIP RD., POOLESVILLE, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it 1 Burial 2 Cremation 3 Removal from State MONOCÁCY ČEMETERY 07/25/2011 BEALLSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BOX 86 P.O. HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death Ph\_sician/ RESPIRATION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 20 days Compulations Sequentially list conditions Physician/Medical Examiner il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed SECOND STUDIES OF MEST and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth
Pregnant
Unknown in the past 12 months? Month Day Year 2 No the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by llation CAD. CABG > 3 1 Tes 2 No 3 Probably 4 Unknown nypertension 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform After this certificate 1 ☐ Yes 2 X No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) xaminer? 1 Yes Other: 2 🗌 No npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural
Accident 5 Pending work? 06,30,2011 Fall out 13 bed. 0400 Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Fisher AVE. Porlesille Mo at home To the Hospital within 24 hours and To the Funeral C Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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State

Registrar

29b. Sign*a*ture and title certifier

ASHIKA

31. Date filed (Month.

GREENE ST.,

19223

BALTIMORE,

20.

MD 21201

2011

MM

S.

32. Ragistrar's Signature

MELLAN

22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIAL

2 2 201

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 2 Date of Death 3. Time of Death Physician/ Mont Medical Examiner last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Funeral Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days Months Hours Month Day, Y Director 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No 10f Zin Code 10g. Citizen of What Country? Funeral permit, Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 Ho Specify: 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, Be Middle, Maiden Surname) မ Informant's Name/Relationship (Type, Print) Cremation 3 - Removal from State injury ( 5 Other (Specify) uneral Service Licen: any mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Fater the disease, o Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last use as the burialattending physician Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery þ in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year been signed by the a should be detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has l page 2 s autonsy performed? 2 No of Vital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Division Accident Suicide after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined the Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) R077623 7-15-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L Thomas 21601 Krystal 501 Dutchmen's Easten MA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical e (if not institution, give stre Examiner Birthplace (State or Foreign Country) last birthday) **Funeral** Director 10c. City, 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 🗆 Yes 2 📉 10g. Citizen of What Country? Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Armed Forces Black, White, 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during (B) NOT use retired) (Specify only highest grade completed) or 5+) conday (0-12) Be ပ 20b. Place of Disposition (N 1X Burial 2 Cremation 3 Removal from State 5 Other (Specify) the disease, or complications that caused the death. Do not enter Interval Between heart failure. List only one of Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consumence of within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and
To the Funeral Director: After this certificate has been signed by the attending physician and Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 2 No 3 Probably 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 🗌 Yes Certificate: To ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 State

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Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_ For	Pleas	<b>se Type</b> State			Black In nd / Depa							-	jible.	
	_	<ul><li>State</li><li>Registrar</li></ul>						tificate					Reg.	N20		25209
Physicia Medic		1. Decedent's Name Harold		_ ′	nodes	;						2. Date of D Month July		Day 2011	Year	3. Time of Death 5:10 A M
Examin		4a. Facility Name (if Moran Ma		•				4b. City, 7		Location				4c. County		
Funeral Director		5. Social Security No. 220-40-1	umber 023	6. Sex 1 <b>X</b> M 2 □		e (In yrs. i 69	last birthday) Yrs.	If Under Months			r 24 Hrs. Min.	8. Date of B (Month, I June	Sirth Day, Yea		9, Birl	thplace (State or Foreign untry)
	ř	Usual Residence of 10a. State	Decedent 10b. County			10c. Cit	ty, Town or Lo	cation				- ourie	20	1742	rial	10d. Inside City Limits
e Marylar 28a-f s notified	)irecto	MD	Allega	ny			Wester	nport								1 <b>X</b> Yes 2 □ No
is 23a oi nust be	by Funeral Director	10e. Street and Num 202 Ri	ordon	Road				10f. Zip	2156	2				Citizen of Inited		
rs after death ıral", or item I Examiner n		11. Marital Status  1  Never Marri 3  Widowed		ed 1 🛣 if Yes	Forces?	Ever in U. No 19	60	Was Decede f Yes, speci 1 ☐ Yes 2	fy Cuba	n, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	O-		ck, White	rican Indian, e, etc. white
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Spe	15. Decedent cify o <i>nly high</i> es onday (0-12)	t grade comple	ted) e (1-4 or	5+)	(Give life. D	dent's Usual kind of work O NOT use Drive	(done d retired)	ation Ju <i>ning m</i> os	st of worki	ing		Kind of B		
d be filed v Mental Hyg arked oth	To Be	17. Father's Name (A	First, Middle, La .liam R	hodes						18. Moth	ner's Nam <b>Et</b> r	e (First, Middle Nel Ha	e, Maide mil		e)	
nd 2 shoul ealth and I n 27 is ma		19a. Informant's Na Wanda Rh					19b. Mailii 202	ng Address Riorda	Street a	oad,	er or Rura <b>West</b>	al Route Numb Cernpor	ber, City	or Town, S Mary]	State, Zij L <b>and</b>	21562
Page 1 ar nent of He ant: If iter ıry or oth			oosition Cremation 5 Cother (Sp		rom State	20b. l	Place of Dispo cemetery, crer UreI H	sition (Nam natory or ot ill Ce	e of her plac <b>emet</b>	ery	07/26	Date 5/2011			-	Town, State ryland
permit. Departr Import. any inji		21. Signature of Fur	neral Service Lic	censee	or	Ċ		2. Name and				oal Fur ernpor				21562
Physician/ Medical Examiner		23a. Part 1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List on Final	ly one cause o	n each lin	e.		er the mode	of dying					racar y a		Approximate Interval Between Onset and Death
be executed sician and burial-transit	cal Examiner	Sequentially list co- if any, leading to im- cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nmediate rlying iinjury s	c	·		uence of): uence of):									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes 1 🔲 I 4 🔲 I	ive Birth	of pregna 2 Fet at time of	al death 3	Ectopic p		у			-		ate of de	livery Day Year
uires that th signed by Ild be deta	by	Part II. Other signif	icant condition	s contributing	to death l	out not res	sulting in the u	inderlying c	ause giv	en in Par	t I.			o use con		o the cause of death?
: The law requ cate has beer page 2 shou	Completed											24a. Wa aut per 1 🔲 Ye	topsy rformed		Were au prior to death?	topsy findings available completion of cause of
sician; certifi	To Be	25. Was case referred examiner?  1  Yes 2	ed to medical	Hospital:		iant O	] ER/Outpatie	+ 2 \ DO	Othe	er		k only one)	4.1	0 - 011		76.4
ending Phy sath. or: After this he funeral d	Certificate: T	27. Manner of Death 1 Natural 2 Accident	h 5 Pending Investiga	28a. E	ate of injudent	ıry	28b. Time of injury		c. Injury work	/ at		ome 5 Re 28d. Describe				
ital or Att urs after de al Directo led in by t	al Certi	3 ∐ Suicide 4 □ Homicide	6 ∐ Could ne determin	28e. P		ury - At h c. (Specif	ome, farm, str iy)	eet, factory,	office			28f. Location City or To			er or Ru	ral Route Number,
the Hosp hin 24 hou the Funer	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										cause(s) and manner stated. stated.					
To witl		29b. Signature and	title of certifier	Shi		MD		r	009	number	25		J	uly :	25,	h, Day, Year)
d	3	30. Name and addre			ause of a		n 23a) (Type, F	Print) Wulst	n Ro	1 C	umbe	erland	MY	2150	)2	
Stat Registra		31. Date filed (Mont)			2. Registr	ar's Signa		Kel								

State of Maryland / Department of Health and Mental Hygien

**Physician** /Medical Examiner

Certificate of Death

Reg. No.

29d. Date signed (Month, Day, Year)

7/21/11

Jalison 12

25210

**Funeral** 

Director items 23a or 28a-f show Iner must be notified at permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinar once.

Director

Funeral

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Completed

Be

death with the Maryland

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death <sup>Day</sup> 2011 July 21, 2:00 A M Arlie Raymond Rounds, Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Garrett Accident 178 Pine Ridge Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Nov. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1926 1 XM 2 ☐ F Maryland 215-26-9350 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 ☐ Yes 2 1 No Accident Md Garrett 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21520 178 Pine Ridge Rd. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 [X] Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 Fire Brick Manufacture Pressman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Jane Broadwater Floyd Columbus Rounds 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 153 Pine Ridge Rd., Accident, MD 21520 Diana Deal/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 3 ☐Removal from State 1 ☑ Burial 2 ☐ Cremation New Germany Meth. Cem. July 25, 2011 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. ture of Funeral Service Licen P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Anset and Death Immediate Cause (Final MO disease or condition resulting in death) Due to (of as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last us a consequence of) 00 Due to (or as a consequence of):

dical		d				
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □Ectopio	c pregnancy (specify)		23d. Date of delivery Month Day Year
þ		contributing to death but not re-	sulting in the underlying	g cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?  ! No 3 Probably 4 Unknow
Completed					24a. Was an autopsy performed?	
To Be (	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Othori	eath (Check only one)  Home 5 Residence	6 □Other (Specify)
	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how inju	iry occurred
Certification	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of injury - At he building, etc. (Spec	ome, farm, street, factify)	tory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
dical (		Physician: To the best of my kn aminer: On the basis of examin and manner stated.				s) and manner as stated. nd place, and due to the cause(s)

29c. License number

NO DO YLLEL - L

DHMH 17 Rev 1/2001

10

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

231

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

athan Ricewick		State of Maryland / Departme 1- For State Certifica Registrar			tal Hygid	ene Reg.	201	1 25211				
Physicia Medical Exami	and 1. Decedent's Name (First, Middle,Last)  Nathan Daniel Ricewick 2. Date of Death  Month Day July 24, 2011  4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death  4c. County of Death											
		4a. Facility Name (if not institution, give street and number) Western Maryland Regional Medical Center		City, Town, or Location o Cumberland			Allegany					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthed)  212-92-3973 1 1 4 2 F 32		ff Under 1 Year If Under Months Days Hours	Min.	Aug 17	( <b>1978</b> ) 9. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7.	Birthplace (State or reign Country				
nd how any cc.	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of Allegany		perland				10d. Inside City Limits 1 X Yes 2 No				
with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number 59 E. Offutt Street		Of. Zip Code	502	10g	. Citizen of What C	country? SA				
r death or ite	y Funeral	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No  3 Widowed 4 Divorced If Yes, Give Yeer	If Yes,	Decedent of Hispanic Orig specify Cuban, Mexican, es 2 X No specify:			14. Race - Ar White, etc Specify: W					
5-0036 led within 72 hours afte Hygiene. I other than "natural", the Medical Examiner	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most	Usual Occupation (Give k of working life, DO NOT		done 1	6b. Kind of Busine					
ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than natic event, the Medical	Be Com	17. Father's Name (First, Middle, Last)  Mitchell Llovd Bennett	<u>lerk</u>		Dana D	Diane R	iden Surname) Ricewick					
MD 21 Id 2 should ulth and Me m 27 is ma	٩	Dale Brakeall step-father	57 E	ddress (Street end Num E. Offutt Street	et	Cur	nberland	MD 21502				
Baltimore, MD 2 pemit. Pages I and 2 shou. Department of Health and N Important: If iten 27 is n injury or other traumatic.			ry or other Memoi			27/2011	Cumbe					
Physician	and MD 215	Approximate Interval										
/Medical Examiner		fail re. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Methadone Intoxi  Due to (or as a consequence of):						Between Onset and Death				
	iner	Sequentially list conditions, if any, leading to immediate cause. Finter Underlying Course										
xecuted 1 and - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
be es	iğ.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  AMENDED 23a, 27, 28a- #8 Per FH G9  23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5 9 Unknown	Fetal	_	-26-11 pregnancy	vt	23d. Date of deli	very Day Year				
i, P.O. Bo ires that the de signed by the be detached f	by Physic	Part II. Other significant conditions contributing to death but not resulting	in the und	erlying cause given in Par	rt I.			o to the cause of death?  Probably 4  Unknown				
of Vital Records, P.O. in Institute that the law requires that the transfer this certificate has been signed by one all director, page 2 should be detailed.	Completed				_	24a. Was an autopsy performed 1 Yes 2	prior ed? death					
Vital Recc Physician: The lar r this certificate ha	To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Out			Nursing Ho	me 5 Re	esidence 6 0	ther:				
SiOn ttendii death. ctor: /	ertification:	1 Natural 5 Rending (Month, Day,Year)		1 Yes 2 X	No <b>S</b> 1	ubject	eet and Number or te) 11212	1 methadone Rural Route Number, City Creek Rd.				
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ledical Co	29a. Certifier (Check only one)  2  Medical Examiner: On the basis of examination and/or invand manner stated.	h occurred		ce, end due	to the cause(	s) and manner as					
To vittle	Me	29b. Signature and title of certifier		29c. License number O.C.M.E.			29d. Date signed (	Month, Day, Year)				
		30. Name and a dress of person o conceted cause of death (Item 23a)  Russell Alexander Mu. Assistant Medical Examiner  31. Date filed (Month, Day, Year).  32. Date filed (Month, Day, Year).	- 10	. Baltimore Street, I	Baltimore	, MD 2122	23					
St	ate	31. Date filed (Month, Day, Year) 32. 32. 33. 33. 33. 33. 33. 33. 33. 33.	Low	2								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2028 M 1CHARD 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mandrin Chesapeake Hospice House Anne Arundel Harwood 7. Age (In yrs. last birthday) Social Security Number 213-58-9516 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dhio Days Hours Min 09/11/1951 Director Usual Residence of Decedent 28a-f show 10a. State notified at 10c City Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2 No Riva 10e. Street and Number 10f. Zin Code ö 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 3235 Breckenridge Way 21140 United States 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 X No Specify: Specify: 3 🗌 Widowed 4 🗌 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed with... \*al Hygiene. \*ar than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Computer Sales Manager Sales Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Department of Health and Menta Important if item 27 is marked any injury or other traumation once. Richard Harper Ruckstuhl, Sr. Bertha Gibbons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki M. Ruckstuhl/Wife 3235 Breckenridge Way, Riva, Maryland 21140 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State Kalas Crematory 07/18/2011 Edgewater, Maryland 4 Donation 5 Other (Specify) 21. Signature of Juneral 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Par 1. Eport the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot, or heart failure. List only one cause on each line. Immediate Cause (Final Contrard Down Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of use as the burial-transit law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day be detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy or Attending Physician: The performed Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide
Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 only one) LD

Registrar

State

3+1

Maryland 21215-0036

Baltimore.

Box 68760

P.O.

Records.

Division of Vital

istrar's Signature

445 Defenselfwy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of Ma	ryland / Depa	artment of H tificate of D			201	1 25213			
i			Registrar  1. Decedent's Name (First, Middle, Last)			incate or D	Catif	O Date of Dooth	NOF U	3. Time of Death			
	Physicia		Thomas	Lester	Simmons	1		July 1	9 20				
	Medic Examin		4a. Facility Name (if not institution, give str		Diminone	4b. City, Town, or	Location of Death		4c. County of D				
	=/(3111111	0.	Anne Arundel Medic	al Center		Anna	apolis		Anne_	Arundel			
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	g.	Birthplace (State or Foreign Country)			
	Director		213-18-3179 Usual Residence of Decedent	NI Z L I	93 Yrs.	,		03-19-19	18 M	aryland			
	ind show at	2	10a. State 10b. County		10c. City, Town or Loc	cation				10d. Inside City Limits			
	faryla Ba-f s tified	Director	MD Anne Arun	de1		Chu	rchton			1 □ Yes 2 🔀 No			
	or 2	₫	10e. Street and Number	uci i		10f. Zip Code	0110011	10g	. Citizen of What	Country?			
	s 23a	Funeral	5510 Deale Churcht	on Road		207:	33		USA				
	death item ner n		111 Marital Otatao	<ol><li>Was Decedent Ev Armed Forces?</li></ol>	11	Vas Decedent of His Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc.			
36	after al", or xami	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 🛣 Yes 2 □ N If Yes, Give Year or Dates. 1 9	1	☐ Yes 2 🗓 No	Specify:		Specify:	White			
Š	hours natura ical E	Completed	15, Decedent's Educ	cation	16a, Deced	lent's Usual Occupa	ation	16	b. Kind of Busine				
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Maryland 21215-0036	e filec ntal H ed otl even	To Be	17. Father's Name (First, Middle, Last)				-	e (First, Middle, Mai					
ž	d Mer mark matic	-	Thomas Clayson  19a. Informant's Name/Relationship (Type	Simmons	5.93	A dalance (Otros et a	Laura	Josephin					
¥	2 sho Ith an 27 is trau		Frances L. Simmons			-		al Route Number, Cit Road, Chur					
ē,	f Hearlitem		20a. Method of Disposition		20b. Place of Dispo	sition (Name of			c. Location - City				
m 0	age ent o nt: If ry or		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Woodfield	natory or other place	· i	3-2011	alesvil	le. MD			
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A.													
m & BEES     William P. Qro   8325 Mt. Harmony Lane, Owings, MD 20736													
			Approximate Interval Between										
~		Onset and Death											
	Medical   Examiner	disease or condition resulting in death)  a. Due to (r as a consequence of):  U(1) (1) (x) ty											
		-e	Sequentially list conditions, b	Chatalatana	Disequence of	mrec	110/						
	red	Examiner	cause. Enter Underlying Cause (Disease or iinjury										
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9 ×	eath certifica attending p	ian/	23b. Was decedent pregnant in the past 12 months?		Petal death 3		У		23d. Date of Month	f delivery Day Year			
Bo	e dea the a	ysic	1 Yes 2 No	4 ☐ Pregnant at g ☐ Unknown	time of death 5 L	Other (specify)							
P.O. Box 687	requires that the de been signed by the should be detached	Completed by Physician/Me	Part II. Other significant conditions con	tributing to death bu	t not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tobac	co use contribut	te to the cause of death?			
S, I	ires t sign Id be	q p	cardiomyopat	hy				1 ☐ Yes	2, No 3[	Probably 4 Unknown			
ord	v requ	olete	Adrenal insul	fficjen!	· Cy			24a. Was an		e autopsy findings available r to completion of cause of			
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a	ian: T artifica ctor, p	Be C	25. Was case referred to medical examiner?			26. PI	ace of Death (Chec						
₹	hysic his ce if direct	မ	1 Tyes 2 No		nt 2 ER/Outpatier		4 L Nursing Ho	ome 5 Residenc		pecify)			
ا م	ling P	Certificate:	27. Manner of Death 1. ☐ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,		work	y at ? Yes 2 □ No	28d. Describe how	injury occurred				
Sior	death stor: /	ţį.	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injur	ry - At home, farm, str		Yes 2 □ INO	28f Location (Stree	et and Number o	r Rural Route Number,			
Division of Vital Records,	after after Direct		4 Homicide determined	building, etc.	(Specify)	33, 143, 13, 13, 13, 13, 13, 13, 13, 13, 13, 1		City or Town, S					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier Certifying Physic	cian: To the best of n	ny knowledge, death	occured at the time	, date and place, ar	nd due to the cause	s) and manner a	s stated.			
	the He lin 24 the Fu	Mec	only one) 3 Certifying Nurse	Practioner: To the b	est of my knowledge,	death occurred at th	e time, date and pla	ce, and due to the ca	use(s) and manne				
	Viit To 1		29b. Signature and title of certifier	141 7 "		29c. License		290	Date signed (M	onth, Day, Year)			
	1		1 onua Xal	N 20			65117		1/19/2	011			
df	W 5+1		30. Name and address of person who con	mpleted cause of de	ath (Item 23a) (Type, F	civay	Annoch	MD 21	40/				
<u>ر</u>	Sta	te	31. Date filed (Month. Day, Year).	32. Registra	An .	-1001	HUGKUI.	1100	141				
	Registra		JUL 2 1	2011 2	news B.	parker	<i></i>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 2011 3:50 Рм AMANDA MCDAVID Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex Days Hours (Month 201/1922 1 □ M 2 🔀 F Virginia Director 213-42-1846 89 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 No Jefferson Frederick MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 3865 Jefferson Pike 21755 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 🔀 Widowed 4 🗌 Divorced White Year or Dates 16a. Decedent's Usual Occupation 15, Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Line American Optical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mary Elizabeth Kaywood Elijah McDavid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3560 Point of Rocks Rd. Jefferson MD 21755 Charles Crummitt, Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ¹X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/25/2011 Brownsville MD Old Brethren Cenetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligense 22. Name and Address of Facility > Robert L & John T Williams Funeral Home, Brunswick MD. 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colitis Phytician/ disease or condition Medical resulting in death) Examiner Week Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the should be detached 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 🗓 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 욘 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pendina s after death.

I Director: Aft
d in by the fur Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Hospital Medical Certifying Physician: Mhe best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 — Coultying Nurce Fractioner: To the best of my 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43091 7-21-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MA 21701 Zaidi MA TOLL Sarad 801 House

State

Registrar

32, Rigistrar's Signature

neur

David Brian Spring
11-05341 Please

**UNK UNK** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 25215
State of Maryland / Department of Health and Mental Hygiene

Decided to State   Text Metal Later   Text Metal		1- For State Certificate of Death Reg. No.													
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy perfo	587 artifica ding p		23b. Was decedent pregnant in the						Ectopic pres	gnancy		Month	D	ay	Year
29b. Signature and title of certifier  29c. License number O.C.M.E.  29d. Date signed (Month, Day, Year) July 18, 2011  30. Nam- and addr ss person who completed cause of death (Item 23a) Pamela E. Sputhall, MD Assistant Medical Examiner  900 W. Baltimpre Street, Baltimpre, MD 21223  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	OX (	sici	1 Yes 2 No 9 Unknow	_   '	time of deatr	5 0	ther (Specif)	<i>"</i>							
29b. Signature and title of certifier  29c. License number O.C.M.E.  29d. Date signed (Month, Day, Year) July 18, 2011  30. Nam- and addr ss person who completed cause of death (Item 23a) Pamela E. Sputhall, MD Assistant Medical Examiner  900 W. Baltimpre Street, Baltimpre, MD 21223  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	the do	튑	Part II. Other significant conditions		h but not resu	ulting in the	underlying ca	ause give	en in Part I.	2	23e. Did tob	pacco use contri	bute to t	he cause of	death?
29b. Signature and title of certifier  29c. License number O.C.M.E.  29d. Date signed (Month, Day, Year) July 18, 2011  30. Nam- and addr ss person who completed cause of death (Item 23a) Pamela E. Sputhall, MD Assistant Medical Examiner  900 W. Baltimpre Street, Baltimpre, MD 21223  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	P.C	<u>[</u>								_	1 Yes	2 No 3	Prob	ably 4 🔲 l	Jnknown
29b. Signature and title of certifier  29c. License number O.C.M.E.  29d. Date signed (Month, Day, Year) July 18, 2011  30. Nam- and addr ss person who completed cause of death (Item 23a) Pamela E. Sputhall, MD Assistant Medical Examiner  900 W. Baltimpre Street, Baltimpre, MD 21223  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ds, requir	ete								1		n 24b. V	Vere aut	opsy findings	available
29b. Signature and title of certifier  29c. License number O.C.M.E.  29d. Date signed (Month, Day, Year) July 18, 2011  30. Nam- and addr ss person who completed cause of death (Item 23a) Pamela E. Sputhall, MD Assistant Medical Examiner  900 W. Baltimpre Street, Baltimpre, MD 21223  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	e law e has l	립								-	perform	ned? c	leath?	_	_
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29b. Signature and title of certifier  29c. License number O.C.M.E.  29d. Date signed (Month, Day, Year) July 18, 2011  30. Nam- and addr ss person who completed cause of death (Item 23a) Pamela E. Sputhall, MD Assistant Medical Examiner  900 W. Baltimpre Street, Baltimpre, MD 21223  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	of Neg Phy		27. Manner of Death	28a. Date of Inj	ury 2 Year)		′′							t collision	
29b. Signature and title of certifier  29c. License number O.C.M.E.  29d. Date signed (Month, Day, Year) July 18, 2011  30. Nam- and addr ss person who completed cause of death (Item 23a) Pamela E. Sputhall, MD Assistant Medical Examiner  900 W. Baltimpre Street, Baltimpre, MD 21223  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ion tendip		Pending	1.147 0044			55	1Yes	2 🗸 No						
29b. Signature and title of certifier  29c. License number O.C.M.E.  29d. Date signed (Month, Day, Year) July 18, 2011  30. Nam- and addr ss person who completed cause of death (Item 23a) Pamela E. Sputhall, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature	or At after d Direct		3 Suicide 6 Could no	at be 28e. Place of I		e, farm, stre	et, factory, c	ffice buil	ding, etc.		or Town, St	ate)			nber, City
29b. Signature and title of certifier  29c. License number O.C.M.E.  29d. Date signed (Month, Day, Year) July 18, 2011  30. Nam- and addr ss person who completed cause of death (Item 23a) Pamela E. Sputhall, MD Assistant Medical Examiner  900 W. Baltimpre Street, Baltimpre, MD 21223  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	apital hours	Š	4 Homicide	(opening) LD						-			_		
29b. Signature and little of certifier  O.C.M.E.  July 18, 2011  30. Name and address person who completed cause of death (Item 23a) Pamela E. Sputhall, MD Assistant Medical Examiner  Pamela E. Sputhall, MD Assistant Medical Examiner  31. Date filed (Month, Pay, Year)  32. Registrar's Signature	the Ho the Fu the Fu	dical	(Check only	er:On the basis of exa	mination and	, death occu l/or investiga	irred at the ti ation, in my o	me, date pinion, d	and place, a leath occurre	and due t ed at the t	o the cause time, date a	e(s) and manner and place, and d	as state	e cause(s)	
30. Name and address a person who completed cause of death (Item 23a) Pamela E. Sputhall, MD Assistant Medical Examiner 900 W. Baltimbre Street, Baltimbre, MD 21223  State 31. Date filed (Month, Pay, Year) 2011 32. Registrar's Signature	S. S. W. is	Σ	29b. Signature and title of certifier	and manner stated	·		29c. I	License r	number			29d. Date sign	ed (Mor	ith, Day, Year	)
Pamela E. Sputhall, MD Assistant Medical Examiner 900 W. Baltimpre Street, Baltimpre, MD 21223  State 31. Date filed (Month, Pay, Year) 2011 32. Registrar's Signature			Linguoti Quith	oll mh			(	O.C.M.	Ε.			July 18, 20	11		
State 31. Date filed (Month, Pay, Year) 2011 32. Registrar's Signature	_	1	30. Name and address a person who												20.5
THE STATE OF THE S	نم			,			0 W. Balt	impre (	Street, Ba	altimore	e, MD 21	223			
			31. Date filed (Month, Day, Year)			1. 4	arked								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ) State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 1210 AM Physician/ uber Harrison 10 01 Medical Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4b. City, 4c. County of Death **Examiner** 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Month, Day Ye Funeral Year 1924 Min. Months Days 1 **X** M 2 □ F Maryland Director Yrs Nov. 219-14-5896 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 X No MD Garrett Grantsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21.536 USA 1739 Durst Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married X Yes 1 Yes 2 X No Specify: White If Yes, Give Completed 3 X Widowed 4 Divorced WW2 Year or Dates 16b. Kind of Business Industry 16a Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Labor Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Dessie Pearce Gurney Spiker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3457 Chestnut Ridge Rd., Grantsville, MD Joseph Spiker/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Durst Cemetery July 24, 2011 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate 23a Part 1. Enter the disease. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Il any, leading to immediate cause. Enter Underlying Examiner Tie to lor as a consequence of signed by the attending physician and be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2. No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ္ဂ 4 Nursing Home 5, Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred completed filled in by the funeral Certificate: within 24 hours after death.

To the Funeral Director: After work? 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionar To the object of the cause of (Check the 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 25217 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death , <sup>Day</sup>20<u>11</u> Physician/ July 19, William Robert Smith 11:27 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ocean City Worcester 503 Robin Drive - 1-E 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 **X** M 2  $\square$  F Days Hours Min 161-38-9911 62 12/28/1948 Pennsylvania Yrs **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No Ocean City Maryland Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 503 Robin Drive, 1-E 21842 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 X Never Married 2 Married White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assistant General Manager Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Isabel Shumski Donald Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Smith/Brother 907 Hillcock Drive, Harrisburg, PA 17111 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Anatomy Gifts
Registry 1 Burial 2 Cremation 3 Removal from State 7/20/2011 Hanover, MD 4 X Donation 5 Other (Specify) Signature of Funeral Service Polloway Funeral Home Professional Associaiton Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition nave Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause, Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes Completed No pinous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) funeral 28b. Time of Certificate: Manner of ath Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 No n 24 hours after death.

e Funeral Director: A bleted filled in by the fu Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F

complete the only one

State Registrar

Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

OBOX1733 SAUSBURY, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 06:38AM William Willis Tubman Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO oastal Hospice at the lake lisbury If Under 1 Year If Under 24 H/s Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Davs Hours Min  $J_{\mathbf{u}}^{(Month, Day, Year)}$ 1923 1 X M 2 - F Maryland 88 **Director** 218-20-3752 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits hours after death with the Maryland 10c. City, Town or Location must be notified at Director Dorchester Cambridge 1 X Yes 2 No or 28a-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a USA 411 Edlon Park 21613 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Black, White, etc ģ 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🔀 No Specify: WWII Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) iewelry store owner/operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, မ Naomi Willis Granville Tubman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9028 Point Lane, Chestertown, MD Anna Ruth Tubman p.r. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Christ Churchyard 7/26/11 Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. Signature of Funeral Service Licenses 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician rallate Carcinon disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and the detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 🗖 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably Wan Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy has page 2 within 24 hours after death. To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: HOCK 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) the funeral 27. Manger of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Natural injury 5 Pending 1 Yes 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63199 7/23/11 Name and address of person who completed cause of death (Item 23a) (Type, Print) DR., SAUSBURY, SHORE

State Registrar 31. Date filed (Month, Day Yea

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 25219 Certificate of Death 1. Decedent's Name (First, Middle, Last)
RICHARD W. 2. Date of Death 3. Time of Death Month 07 Year Day 21 Physician/ Iranmer 2:24 AM Medical Facility Name lif not institution, give street and number Iniversity D) Maryland Medical Center 12 S. Crepaine Street 4b. City, Town, or Location of Death Baltimore 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours (Month, Day, Year) 09-17-1960 Wash. 1 🕅 M 2 🗆 F Director 214-84-2704 50 D.C Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sho idical Examiner must be notified at 10c. City, Town or Location with the Maryland Director 1 ☐ Yes 2 🕅 No North Beach MD Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 3644 9th Street 20714 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Completed and Mental Hygiene.
is marked other than "natural raumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry within 72 paper, maintenance & Elementary/Seconday (0-12) College (1-4 or 5+) restaurant supplies Sales Executive Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Heath and Mental Important: If item 27 is marked any injury or other traumatic ev-once. ည Judith Ann Cecil Preston Eugene Tranmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20639 2665 Hidden Hill Court, Huntingtown, MDJudith A. Tranmer, mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 07-27-11 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 10020 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final static Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of: Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Munknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No page 2 After this certificate 25. Was case referred to medica Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify, 2 No Hospital 1 🗌 Yes မြ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending within 24 hours after death. To the Funeral Director: A 2 🗌 No 2 Accident Investigation the 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one) 3 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar

DHMH 17 Rev 7/2009

30. Name and

31. Date filed (Month, Day, Year)

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32. Registras Signature

Paw, MD; 225 Greene Sheet, Buttomore, MD 20866

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shley N. Throck		rton State of Maryland / Department of 1-For State Certificate of Registrar		ental Hyg	jiene Reg.	201	1 25220
Physicia Aical Exami	in/	1. Decedent's Name (First, Middle,Last) Ashley Nicole THROCKMORTON	-		Date of Death	ay Year	3. Time of Death 0811 hrs
	3-1	4a. Facility Name (if not institution, give street and number) Western Maryland Health System	4b. City, Town, or Locati			4c. County of Deat	h
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 220-11-6683 1 M 2X F 25 Yrs	Months Days H	Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. Bi	
,		Usual Residence of Decedent  10a State 10b. County 10c. City, Town or Locat	<u>ll</u>		000113	,1703	10d. Inside City Limits
ind sbow any ace.	'n	Maryland Allegany Lonaconin					1 X Yes 2 No
ne Maryland or 28a-f sbow fied at once.	Director	10e. Street and Number 6 Robin Street	10f. Zip Code	539	10g	Citizen of What Cou	intry?
ath with the terms 23a	Funeral [	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	as Decedent of Hispanic es, specify Cuban, Mex	Origin? (Spec			rican Indian, Black,
after de: ral", or i	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No spe			Specify:	hite
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during m	nt's Usual Occupation (G lost of working life. DO N ⊇maker			6b. Kind of Business.  her own	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Comp	17. Father's Name (First, Middle, Last)		other's Name (F	irst, Middle, Ma	iden Surname)	
2121 ould be fil Mental E marked	o Be	Clyde Edward Throckmorton  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing	g Address (Street and	Number or Rur		Jean Owen er, City or Town, State	
MD ind 2 sho ealth and em 27 is			Dale Street			Maryland  20c. Location - City o	
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.					
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Box e death ce the attenced for use	Physician/N	1 ✓ Yes 2 No 9 Unknown Pregnant at time of death 5 0 Of 9 Unknown	ther (Specify)				
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of Vital Records, in Physician: The law requirement that the continue has been sineral director, page 2 should be	Completed				24a Was an autopsy	prior to	utopsy findings available completion of cause of
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Vita	To Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient	DOA Other	4 Nursing	Home 5 R	esidence 6 Othe	er;
on of cending I sath. or: Afte		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of	Injury 28c. Injury at V		8d. Describe ho	w injury occurred	
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Functal Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transil	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, stre	et, factory, office buildin	ng, etc. 2	8f. Location (Str or Town, Sta		ural Route Number, City
Di To the Hospital within 24 hours a To the Funeral I completely filled	Medical Ce	4 Homicide  29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigal	rred at the time, date an	nd place, and do	ue to the cause(	s) and manner as stand place, and due to t	ited he cause(s)
To with	Med	and manner stated.  29b. Signature and title of certifier	29c. License nun	mber		29d Date signed (M	
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	-		August 1, 2011	
	ole	Melissa Brassell, MD Assistant Medical Examiner 900 V		t, Baltimore	e, MD 21223	3	
St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 08 2011 32. Teglstrar's Signature	Med				

DOME

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death  $1^{\text{Day}}$ Physician/  $\mathbf{J}_{\mathbf{u}}^{\mathsf{Month}}$ 201T 1:03 Pм Triandos-Triantafillides Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Harwood Mandrin Hospice House . Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 2/25/1936 1 M 2 505 74 **Director** 577-58-9928 Greece Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director Anne Arundel Annapolis 1 ☐ Yes 🕱 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21403 USA 140 Great Lake Dr. items Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XXN0 Baltimore, Maryland 21215-0036 USA 1 ☐ Yes 2 No Specify. Specify: Year or Dates 27 is marked other than "natural traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Fashion Dress Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hitem 27 is marked of other traumatic even မ UNK Maria John Sermley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City, MD 21042 <u>Demetrea Triantafillides</u> Daugh 9804 Woodbridge Ct. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 7/15/2011 Annapolis, Md Demetrius 21. Signature of Funeral Se 22. Name and Address of Facility Hardesty Funeral Home, P.A. Ridgely Ave. Annapolis, MD 21401 12 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events tranand Due to (or as a consequence of): resulting in death) Last the burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 N Io the recent within 24 hours after death.

To the Funeral Director: After this certifics

-1→→← filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: ပ္ 1 L Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1. Natural 5 Pending injury Accident 1 Tes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 028686 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) 10 D O Date filed (Month) State JUL 2 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25222 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $22^{\text{Day}}$  $J_{\mathbf{u}}^{\mathrm{Month}}$ 201<sup>Year</sup> 8:45 a.M Valliant Beverly Dill4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death William Hill Manor Easton Talbot 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) Months Days Hours Aug. 22, 1919 1 M 2 X F 212-18-6073 91 Yrs Maryland Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 1 🛣 Yes 2 🗆 No MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 515 Glenburn Ave. Unit 203D 21613 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. white 1 ☐ Yes 2 K No Specify: 3 ¥ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles K. Dill Bertha Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Jones 157 E. Main St., Elkton, MD nephew 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State rematory of Delmarva 7/23/11 Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final STAGE RENAL DISEASE disease or condition resulting in death) ATHERD SCLEROTIC CARDIOVASCYLAR DISEASE Sequentially list conditions,

Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and attending physician Division of Vital Records, P.O. Box 68760 for use as signed by the a page 2 should after death.

Director: After this certificate | completed filled in by the funeral director, within 24 hours a

To the Funeral D

Physician/

Medical

**Examiner** 

**Funeral** 

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items 23a or 28a-f shov

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permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

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Baltimore, Maryland 21215-0036

Examiner must be notified at

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Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):			1/2	it.
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnate 1 Live Birth 2 Fet. 4 Pregnant at time of 9 Unknown	al death 3 🗌 Ectopi	ic pregnancy (specify)		23d. Date of del Month	ivery Day Year
Part II. Other significant conditions of CEREBRO VASC	_	_			2 No 3 □ Pi	the cause of death?
				24a. Was an autopsy performed?	prior to d	topsy findings available completion of cause of
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examiner?	Hospital:	ER/Outpatient 3 🗌	Other:	lome 5 Residence	6 ☐ Other (Spec	16.5
	1 Li Inpatient 2 L	Erroutpationt o -	DOM 42 Nulsing I	IOTTIC B III TICSIGCITOC	O - O LITTOT   O DOG	ity)
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1  Yes 2 No	28d. Describe how inju		ify)
27. Manner of Death  1   Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury  M  ome, farm, street, fact.	28c. Injury at work? 1 □ Yes 2 □ No		ury occurred  and Number or Rui	

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BLOOMING DALL AUG FEDSCALS BURG

State Registrar of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Hilda Smith Velasquez 10:55a Medical Julv 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11812 Arrowhead Trail Lusby Calvert Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 💢 F (Month, Day, Year) 7/2/1930 Months Hours Min. Country) Director 243-42-8468 81 NC Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Merical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11812 Arrowhead Trail 20657 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. \$ 1 Never Married 2 M Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. Heating and Air life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Conditioning Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be file th and Mental H 27 is marked of traumatic ever Duncan Monroe Smith Stella Lee Morton permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Eustis Ave. Sheila Magoon/Daughter Wakefield, MA 01880 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Vets. 7/26/11 Cheltenham, MD 22. Name and Address of Facility 21. Signature of Funeral Service Libensee Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) au Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by or Attending Physician: The law requires t 1 🗌 Yes 2 🗌 No 3 🗔 Probably 🔎 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: 28b. Time of 1) Natural 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After 5 Pending work 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

dRW

Baltimore.

Box 68760

P.O.

Records,

of Vital

Division

State Registrar 31. Date filed (Month, Da

son who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

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		I- For State Registrar			Certific	ate of	Death				Reg. No	).		4444
Physicia Medical Examin	n/ er	1. Decedent's Name (First, Middl Jonathan Wils	on Wilkir						2	2. Date of D Month July 20,	Day 2011	Year		3. Time of Death 1801 hrs
		4a. Facility Name (if not institution 512 S. Park Drive	n, give street and r	number)		4	b. City, Town, o	r Location	n of Death			lc. County o Wicomic		
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last bi	rthday)	If Under 1 Ye		der 24Hrs.	8. Date of	Date of Birth(MM/DD/YYYY) 9. Birthp			hplace (State or Maryland
Director		217-90-2410	1XM 2F		39	Yrs.	Months Da	ys Hou	ırs Min.	09/0	8/19	71	Cou	untry)
Au a	ŀ	Usual Residence of Decedent  10a. State 10b. County		Ī	I0c. City, Town	n or Location	on							10d. Inside City Limits
k	5	Maryland Wicom	nico		Sa	alisbu	ury							1 X Yes 2 No
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AOFE ages 1 nt of H nt: If it		1 Burial 2 X Cremation		from Stat	٥	tory or oth	erplace) f Delmar	79	7/22	/2011	De	1mar	De.	laware
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shouling or other traumatic event, the Medical Examiner must be notified at once.	-	4 Donation 5 Other State 21. Signature of uneral Service	pecify:	2	101011		ame and Addres							
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68760, ertificate be ding physic e as the burn	an/N	23b. Was decedent pregnant in the past 12 months?	ne 1 Live	birth		2 Fet		Ector	oic pregnanc	су		Month		ay Year
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F Vita		examiner? 1 Yes 2 No	Hospital: 1	Inpatien		Outpatient		Other <sub>4</sub>				lence 6	-	Scene
Division of Vital Records, P.O. fal or Attending Physician: The law requires that the safer death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted.		27. Manner of Death  1 Natural 5 Pend	(Mon	e of Injur th, Day,Ye '-20-	ar)	5:56		uryatWo Yes 2	_	J <b>nknow</b>		jury occurre	ū	
ViSic or Atte fler dez Directo in by tl	Certification:	3 Suicide 6 K Coul	d not be				t, factory, office	building,	etc. 2					ral Route Number, City
Divisior ospital or Attent hours after death meral Director: y filled in by the		4 Homicide	rmined (Specify		Resid					alisb	ury,	Md.		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only	hysician: To the be miner:On the basis and manner	of exam	_									
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		<ol> <li>Name and address of person Donna M. Vincenti, M</li> </ol>			atn (Item 23a) al Examine		W. Baltimor	e Stree	t, Baltimo	ore, MD 2	21223			
Sta Registr		31. Date filed (Month, Day, Year)		Regirtrar	s Signature	1	arkel		-					
DHMH 17 Rev 1/20		JUL	OGME	Consta	OI	RIGINAL						•		
OCME 2006					٠.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ns Medical 4a. Facility Name (if not institution give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death oai . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 XF Months Hours Min (Month, Day, **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at within 72 hours after death with the Maryland 10b. Coul 10c. City, Town or Location 10d. Inside City Limits Director 1 No Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Ve items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian If item 27 is marked other than "natural", or ite or other traumatic event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 N Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working iffe. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be mer's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) 2 should be formant's Name/Relationship (Type, Print) Rural Boute Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory Donation 5 Other (Specify) minution Sign Funeral S 22. Name and Address of . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ementio disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burlal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Vear the g Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic celitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No death? 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 \sum Yes ျှ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this funeral Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) I Director: After to d in by the funera 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide within 24 hours a To the Funeral D Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature ar 29d. Date signed (Month, Day, Year) MD D0062190 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

JUL 26 2011

SHAHNAWA Z

KHANMD, 2533 AUGUSTINE HERMAN HWY, SUITE A, CHESAPEAKECTY, MD 21915

32. Registrar's Signature

32. Again

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.20 25226 Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 8930 DWARD Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Anne Arundel Millersville 476 Old Orchard Circle Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** (Month, Day, Months Days Hours 705-10-9244 96 Yrs 1915 Maryland Director Jan. Usual Residence of Decedent 28a-f show items 23a or 28a-f shoner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Millersville Anne Arundel MD 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 476 Old Orchard Circle 21108 je 1 and 2 should be filed within 72 hours after death v t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Clerk Railroad 12 event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ulth and Mental F 27 is marked or r traumatic eve မ Edward John Weber, Sr. Anna Gosnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 550 M Ritchie Hwy, P.M.B. 150 Severna Park, MD Diane Cary / Daughter other Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Glen Haven Memorial Park Cemetery 1 X Burial 2 Cremation 3 Removal from State ō Department of Important; If any injury or once. Glen Burnie, MD 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Sater to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feiture. List only one cause on each line. Approximate Interval Between EREBROVASCULAR Immediate Cause (Final et and Death Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of): **Examiner** SEASE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on Exami and burial-tran Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical certificate be P.O. Box 68760 signed by the attending particle by the detached for use as: IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known Completed After this certificate has been sistumeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? Yes 2 No Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifical eted filled in by the funeral director, p. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 II NO မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Médical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 completed cause of death (Item 2 Name and address of person a) (Type, Print)

CAS

State 31. Date filed (Month, Day, Year)
Registrar

TENEVIEVE

0 2011

TGHTFOOT-TAYLOR

011 32. Rigistrar's Signature

MOR, 445 DEFENSE HWY, ANNAPOLIS, M.D. 21401

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

CI DHMH 17 Rev 7/2009

			Pleas	se Type or Pri						_		_	∍.	
	-	For State		State of M	arylan		partment ertificate					2011	25	227
		Registrar  1. Decedent's Name	e (First, Middle,	Last)			erinicate	OI L	Jean I	2. Date of De		<u>4-011</u>	3. Time of	
Physicia Medic		Burne	ette	Lorra	aine		Zyke	es		July	23	, 2011	5:1	5 A <sup>M</sup>
Examin				give street and number) Health & Rel	hab	C+r			Location of Death	1	4c. County of Death Prince George's			
∘ Funeral		5. Social Security No	umber 6		e (In yrs. k	ast birthda	y) If Under 1		If Under 24 Hrs. Hours Min.	8. Date of Birl	th	100	irthplage /State	or Foreign
Director		579-40-( Usual Residence of		T L M Z LALF	94	Yrs	.			087297	191	6	Mich	igan
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State	10b. County			y, Town or							10d. Inside (	City Limits
he Mar or 28a s notifi	L= L	Maryland 10e. Street and Nun		e George's	Ft	. Wa	shingtor 10f. Zip C			1	10a. C	itizen of What (		es 2 Erno
s 23a nust be	eral	12021 Li	vingsto	n Road				20	744			USA	,	
r death r item iiner m		11. Marital Status	ind 2 Marris	12. Was Decedent I Armed Forces?		3. 1	<ol> <li>Was Deceder If Yes, specify</li> </ol>	nt of Hi Cuba	ispanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- p Rican, etc.)		14. Race - An Black, Wh		
ırs afteı ıral", o I Exam	ed by	3 X Widowed		ed 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates.	No		1 ☐ Yes 22	<b>X</b> No	Specify:			Specify:	White	
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within giene. er thai		12 years	onday (0-12)	College (1-4 or 8	5+)		lerk	etir ea)			]	Red Cro	ss	
e filed ntal Hy ed oth event	To Be	17. Father's Name (							18. Mother's Nar Mary	ne <i>(First, Middle,</i> Viola		Surname) Fisher		
nould b nd Mer s mark smatic		Herbert  19a. Informant's Na		win Grow  O (Type, Print)		19b. M	ailing Address (S	Street a	and Number or Ru					
nd 2 sh ealth a <b>n 27</b> is ier trau			Sweet /	/ Nephew					O East Ro					550
ige 1 an nt of H t: If itel		_	☐ Cremation 3	B ☐ Removal from State	_ c	emetery, c	sposition (Name rematory or other	er plac		Date		ocation - City		
mit. Pa bartme bortani r injury		4 ☐ Donation 21. Signature of	5 Other (Sp eral Service Lic		Ke	surre	22. Name and		ss of Facility Ge	26/2011			Maryla eral Ho	
permi Depar Impo any ir		14	11.1	Calo			6160 Ox	on	Hill Roa	d Öxon	Hil.	l, Mary	land 2	0745
			rt failure. List on	omplications that caused ly one cause on each line	∍.						rest,		Approxima Interval Be Onset and	etween
Physician/ Medical		disease or conditio resulting in death)		a. ATHEI			IC CARDI	<u> </u>	ASCULAR I	DISEASE			year	S
Examiner	Je.	Sequentially list conditions, b.    Due to (or as a consequence of):												
ted J unsit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or	rlying iinjury		a consequ	uence of):								
be executed sician and burial-transit		that initiated events resulting in death) I		C. Due to (or as	a consequ	uence of):								
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical			d										
oertifi ending r use a	an/M	IF FEMALE: 23b. Was decedent		23c. If yes, outcome 1  Live Birth			3 □ Ectopic pre	eananc	:v			23d. Date of c	delivery	
e death the att thed fo	ıysici	in the past 12 r 1 ☐ Yes 2 ☑ 9 ☐ Unknown		4 ☐ Pregnant a 9 ☐ Unknown			5 Other (spec					Month	Day	Year
that th ned by e detac	by Ph	Part II. Other signif	icant condition	s contributing to death b	out not res	ulting in th	e underlying cau	use giv	en in Part I.	23e. Did to	obacco	use contribute	to the cause of	death?
equires een sig rould b	ted !									1 🗆	Yes 2		Probably 4X	
e law re e has by ge 2 sh	Completed									24a. Was autop perfo	osy rmed?	prior to death?		
ian: Th rtificate tor, pa	Be Cc	25. Was case referre	ed to medical					26. Pla	ace of Death (Che	1 Yes	2 <b>X</b> N	lo 1 □ Y	′es 2 □ No	
Physici this ce al direc	욘	examiner? 1 Yes 2	No				tient 3 DOA		A Mursing F	lome 5 Resid			ecify)	-
th. : After e funer	Certificate:	1 XNatural 2 Accident	5 Pending Investiga			28b. Time injur		lnjung: work 1 🔲		28d. Describe h	now inju	ry occurred		
r Atter ter des irector ir by the	ertifi	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ot be 28e Place of Inju	ury - At ho	me, farm,	street, factory, o	office		28f. Location (S City or Tow			Rural Route Num	nber,
spital o ours af ieral Di filled ir	cal C	29a. Certifier 1	X Certifying F	Physician: To the best of	my knowl	edge dea	th occured at the	e time	date and place a				stated	
he Hos lin 24 h he Fur ppleted	Medical	(Check 2	☐ Medical Ex.	aminer: On the basis of e lurse Practioner: To the	xamination	n and/or in	vestigation, in my	opinio	on, death occurred	at the time, date a	and plac	e, and due to th	e cause(s) and m	nanner stated.
Norith Con		29b. Signature and	title of certifie	1			29c. L		number 19431			ate signed (Mor $^\prime 25/201$		
ا ہر ہ		30. Name and addre		completed cause of d	eath (Item	23a) (Typ	e, Print)					,		
15		Frank M						Ft	. Washin	gton, Ma	ary1	and 2	20744	
Stat Registra	e ar	31. Date filed (Month	6 2011	32. Registr	s Signa	ach	/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 = State Registrar	Certificate of Death	Reg.	140:	25228
П	Physicia	an/	1. Decedent's Name (First, Middle, Last)  Mary Cecelia Auer		Date of Death     Month	Day Year	8. Time of Death A
	Medie Examir		4a. Facility Name (if not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Death Baltimore	August	4c. County of Death	
N.	Funeral Director	Γ	5. Social Security Number 220-32-3021 6. Sex 1 $\square$ M 2 $\square$ F 7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth (Month, Day Yea May	9. Birthplac Country) 1937 Baltimor	e (State or Foreign re, Maryland
	Aaryland 8a-f show tified at	rector	Usual Residence of Decedent  10a. State  10b. County  Maryland Baltimore  Par	r Location kville			Inside City Limits 1  Yes 2 No
	s 23a or 2 uust be no	Funeral Director	10e. Street and Number 9009 Wood Park Court	10f. Zip Code 21234		Citizen of What Country? United States	?
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🌠 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American I Black, White, etc. Specify: White	ndian,
21215-0036	within 72 ho giene. er than "na , the Medic.	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)  1 2	ecedent's Usual Occupation ilive kind of work done during most of work e. DO NOT use retired) coount ant	king	o. Kind of Business Indust	
Maryland	ld be filed Mental Hy rarked oth atic event	To Be			ne (First, Middle, Maid Snyder	len Surname)	
, Mar	id 2 shou salth and n 27 is m er traum			Mailing Address (Street and Number or Ru 09 Wood Park Court			
Baltimore,	Page 1 arment of Horant: If iter			isposition (Name of crematory or other place) uneral Chapel Augu LAir 201	ost 11, Fo	c. Location - City or Town, prest Hill, Mar	
Balt	permit Depart Import any inj	J	21. Signature of funeral Service Linense	22. Name and Address of Facility Evans Funeral Cha 8800 Harford Road	pel & Cre , Parkvil	amation Service 11e, MD 21234	es .
	Physician/ Medical Examiner	e X	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to r as a consequence of	etta ck		Int Or	proximate perval Between paset and Death
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8760	cate be cate be physicials the burner	Medical	d				
. Box 68	ath cert attendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Da	y Year
ds, P.O.	requires that the dea been signed by the a should be detached t		Part II. Other significant conditions contributing to death but not resulting in HYPER TENSION	he underlying cause given in Part I.		co use contribute to the c	
Division of Vital Records,	sician: The law rec certificate has bee irector, page 2 sho	Completed by			24a. Was an autopsy performed 1 \(\sum \) Yes 2 \(\begin{array}{c} \text{X} \end{array}	l? death?	etion of cause of
Vital	ysician: is certific director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:  1 Inpatient 2 FR/Outp	26. Place of Death (Chec		e 6 Other (Specify)	
on of	iteriding Ph death. tor. After thi the funeral	Certificate: 1	27. Manner of Death  1 Natural  28a. Date of injury (Month, Day, Year)  28b. Tin inju 2 Accident Investigation	e of 28c. Injury at	28d. Describe how in		
Divisi	ortal or Att		4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)		City or Town, St		ute Number,
	io the Hospital or vithin 24 hours after To the Funeral fire completed filled in the	Medical	29a. Certifier (Check check conty one)  1	vestigation, in my opinion, death occurred a	at the time, date and pla	ace, and due to the cause(	s) and manner stated
0	vitt Con		29b. Signature and Aitle of certifier  August Augus	29c. License number D 0062		pate signed (Month, Day,	
			30. Name and address of person who completed cause of death (Item 23a) (Type NADER HANNA 22 S.	Greene Street	Balt	imore, MD	. 21201

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar	,	artment of He <i>tificate of De</i>		lental Hyg	eg. N2011	25229
H	Physicia	ın/	Decedent's Name (First, Middle, La	st) E - AY	(D			Date of Deat     Month	h Day Year	3. Time of Death
	Medic Examin	al	4a. Facility Name (if not institution, give			4b. City, Town, or L	ocation of Death	Augus	4c. County of Dear	1:16A M
Sept. M	ì		8405 Hallmark			Parkvil			Baltimore	
I	Funeral Director			Sex   <del>Se</del> M 2 □ F	n yrs. last birthday) Yrs.		Hours Min.	8. Date of Birth (Month, Day, 4/22/19	Year) 9. Bir Co M	thplace (State or Foreign untry)
	show at	or	Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Maryla 28a-f otified	irect	MD Baltimo:	re	Parky	7ille				1 ☐ Yes 2 🛂 No
	with the is 23a or nust be n	Funeral Director	10e. Street and Number 8405 Hallmark C	ircle		10f. Zip Code 21234			10g. Citizen of What Co USA	ountry?
9800	filed within 72 hours after death with the Maryland tal Hygiene. Set of them "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	b	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 A Yes 2 No If Yes, Give Year or Dates.	l li	Vas Dec <i>e</i> dent of Hisp f Yes, specify Cuban, ☐ Yes 2 <del>पू</del> No	Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
Baltimore, Maryland 21215-0036	ed within 72 hou Hygiene. other than "nat ent, the Medica	Completed	15. Decedent's II (Specify only highest green (0-12)	Education rade completed) College (1-4 or 5+)	(Give I life. Do	lent's Usual Occupati kind of work done dur O NOT use retired) ial Servic	ing most of worki	ng	16b. Kind of Business  Verizon	Industry
pue	be filed vental Hyg rked othe ic event,	To Be	17. Father's Name (First, Middle, Last)		т орес		8. Mother's Name		Maiden Surname)	
aryla	should be file h and Mental H 7 is marked o traumatic eve		Charles Ayd  19a. Informant's Name/Relationship (	Type, Print)	19h Mailir	no Address (Street and		t Sturm	City or Town, State, Zi	o Code)
Ž,	1 and 2 should be fi if Health and Mental item 27 is marked other traumatic ev		Marilyn Ayd/spo	ıse	1	Hallmark C				234
imore			20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Spec		-	sition (Name of natory or other place) <b>Crematory</b>		Date .	20c. Location - City or <b>Maryland</b>	Town, State
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	Renet	22	Name and Address 9705 Bela			Funeral Hogham, Md.	ome, Inc. 21236
П			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.		_	such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
Ē	Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a c	onsequence of):	ementia				Onset and Death
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0	cate be executed physician and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as a c	onsequence of):					
8760	tificate ng phys as the	Medi	IF FEMALE:	d						
. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of  1  Live Birth 2  4  Pregnant at til 9  Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Division of Vital Records, P.O.	equires that the sen signed by could be deta	by	Part II. Other significant conditions of	contributing to death but	not resulting in the u	nderlying cause giver	n in Part I.		pacco use contribute to	the cause of death?
Recor	sician: The law re certificate has be rector, page 2 sh	Completed	25. Was case referred to medical					24a. Was a autops perform 1 \square Yes	med prior to death?	topsy findings available completion of cause of
Vita	ysiciar is certif	To Be	examiner?  1 \sum \text{Yes} 2 \sum \text{No}	Hospital:	2 ER/Outpatien	Other	e of Death (Check		ence 6 🗆 Other (Spec	eifv)
on of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate: 7	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigatio	28a. Date of injury (Month, Day, Y	28b. Time of	28c. Injury a work?			w injury occurred	ny)
Divisi	tal or Atters as after de al Directo		3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		- At home, farm, stre Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	(Check 2 L Medical Exam	rsician: To the best of my iner: On the basis of exar se Practioner: To the bes	nination a <b>nd</b> /or invest	igation, in my opinion,	death occurred at	the time, date an	d place, and due to the	cause(s) and manner stated.
	Notity With To t		29b. Signature and title of certifier  MSRY UP				00574	65	9d. Date signed (Mont. 8/3/11	
			30. Name and address of person who N , S . Rajapakk			min A	5-20	3 Bn1	timore M	D 21209.
	Stat Registra		31. Date filed (Month, Day, Year) AUG 0 9 2011	32. Registrar's	Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Anderson Month Physician/ 14:501M taul August 201 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** Baltimore NIA Johns HOP KING HOSPITA + If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Date of Bill. (Month, Day, **Funeral** 1 🗶 M 2 🗆 F Days Min. 50-0139 62 Yrs. Director Maryland Usual Residence of Decedent or items 23a or 28a-f show 10b County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at by Funeral Director 1 Xves 2 No Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? United States 21205 North Avenue enwood Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify: Specify: 13/ack and Mental Hygiene. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 t Nd evson Ed was od t. Page 1 and 2 should by tment of Health and Mer tant; If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 09 160. is wood permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔲 Burial 2 🔀 Cremation 3 🗀 Removal from State emetery, crematory or other place 2011 Crematory 4 Donation 5 Other (Specify) 22 Name and Address of Facility Signature of Funeral Service Licensee once. WICL CALVIN Glow Z. MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final isease Physician/ -ardioVASuula disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consecuence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last physician Be Completed by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Yes 2 No 1 Yes 2 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autops, performed? 2 No 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1-X Yes Hospital: Other: ၉ 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES - 000 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WolfeSt 600 N Khandker

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST Nicholas Thomas Bassetti 03:45PM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE N/A HOSPITAL OF | Hours | Hours | Min. | Month, Pay Year | Min. | Nov. 1, 1922 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 😿 M 2 🗆 F Director 217-16-3702 Mary Tand Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 14☐ Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25 South Potomac Street 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 IX Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Speciahite Completed 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Director of Reserve 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anthony Bassetti Marie Dunhouser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
25 South Potomac Street-Baltimore, Maryland 21224 Mary Engelbrecht-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens Of Fait 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Aug.9,2011 Rossville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Faith 21. Signature of Funeral Service Licensee 22. Name and Address of Facility s Funeral Chapel and Cremation Services Harford Road-Parkville, Maryland 21234 Fast 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition DAY Medical resulting in death) Examiner UROSEPSIS DAYS 'YED MOYIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte d be detached for 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERNATREMIA, HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed COMGESTIVE HEART PAILURE Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 ☐ Yes 2 🗙 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 24 hours after deam Funeral Director: / Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) durate AUGUST 2, 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

BHATIA

31. Date filed (Month, Day, Year)

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1AKIZ-

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760

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HOSPITAL

OF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day July  $201_{1}^{\text{Year}}$ 31 Amelia A. Bajkowski 10:40  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Light House Assisted Living Essex 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** 8. Date of Birth 1 🗆 M 2 🕱 F Months Days Hours June 24 West Virginia Director 213-18-3507 97 1914 Usual Residence of Decedent Show should be filed within recoverable and Mental Hygiene.

77 is marked other than "natural", or items 23a or 23a-f shown are event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21221 1813 Old Eastern Ave. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed 10 Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Catherine Surdyka Sagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Loretta Hutchins/ Daughter Baltimore, MD. 21219 7844 Denton Ave. 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory Gardens of Faith Cem. 8-11-11 Overlea, MD. 4 Donation 5 Other (Specify) 21. Signature of Fuheral Service Li-22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home. Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Metastatic Physician/ Darcoma years disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unuerlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) nding physician ause as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐ Pregnant at time of death☐ Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 🗌 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No Assisted Liv မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Sp 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Matural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifie LX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D52496 2011 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buite 145, Lutherville, MD 21093 10753 tallskd MD

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 25233 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7th 2011 Eleanor Audrey Bowser 8:35 August Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2825 Lodge Farm Road, #319 Sparrows Point Social Security Number If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 XF Jan. 26. . 1933 Great Britain Months Hours Min. 212-42-0595 78 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director notified 1 ☐ Yes 2 🗙 No Maryland Baltimore Sparrows Point 10e Street and Number 10f. Zip Code ö 10g, Citizen of What Country? must be Funeral 23a 21219 United States items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 Never Married 2 Married "natural", or Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Homemaking Homemaker 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. Robert Thomas Turner Emily Sollars 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2907 Wells Ave., Sparrows Point, Maryland 21219 Stacey McElwee / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 08/08/2011 | Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ VOULAK PNEUMOPATHY PAK Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if an leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) nding physician and use as the burial-transi Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months 1 Yes 2 No Month Day Year Pregnant at time of death the g Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 s autopsy 1 Yes Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No di di ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury accurred After work? injury 1 Natural 5 Pending Accident Investigation after death

Director: A

d in by the fi 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours after

To the Funeral Dire

completed filled in b Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29h. Signature and title of certifie 30. Name and address of person WORTH CHARLES STROET BALTIMIKE MOZIZER

Registrar

State

31. Date filed (Month, Day,

32. Registrar's Signature

23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or City or Town, State) 500 HESUH/E 140 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) GTRIMBLE HILL OF LUTHERVILLE MD

7:00 PM

Birthplace (State or Foreign Country)

WHITE

MD

10d. Inside City Limits

1 ☐Yes 2 No

21208

Approximate Interval Between Onset and Death

04, 2011

USA

Specify.

4c. County of Death

BALTIMORE

14. Race - American Indian, Black, White, etc.

BALTIMORE, MD

DHMH 17 Rev 1/2001

State

Registrar

death.

after death Director;

To the Hospital within 24 hours a To the Funeral D

completely filled in by the

Medical

2 Accident 3 ☐ Suicide

4 Homicide

(Check only

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

AUG 0 9 2011

FHILIP MILITELLO

29a. Certifier

6 Could not be

determined

28e. Place of njury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

32. Registrar's Signature

parke

and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

29c. License number

11-05805 Benjamin Barnhard Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2011 25235 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar					Certifica	ate of	Death	1				Reg. No.				
Physicia edical Exami	an/	1. Decedent's Name	e (First, Middle,Last) 2. Date of Death Month Da August 2, 20									ath Day	Year		3. Time of Death 1424 hrs			
\$		4a. Facility Name (if 8 Simms Co		on, give s	treet and nu	ımber)		4	b. City, To		ocation of			4c. (	County of			
F		5. Social Security No		6. Sex		7. Age (in y	rs last birt	hday)	I If Unde	r 1 Year	If Under	24Hrs.	8. Date of B	irth (MM/D	D/YYYY)	9. Birth	irthplace (State or	
Funeral Director		212-53-93			2F	1.3		Yrs.	Months	_	Hours	Min.		/1998	998 Foreign Country) MD			
vfaryland 28a-f show any d at once.	ō	Usual Residence of 10a. State MD	Decedent 10b. County Mont	gome1	сy		City, Town ensin		on								10d. Inside City Limits  1 Yes 2 YNo	
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Num 8 Simms							10f. Zip 208					10g. Citize	en of Wha	at Coun	try?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 X Never Marrie  3 Widowed		larried	2. Was Dec Armed F 1 Yes Yes, Give Yes	orces?	dent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Speces?  14. Was Decedent of Hispanic Origin? (Speces?  15. Was Decedent of Hispanic Origin? (Speces?)  16. Yes, specify Cuban, Mexican, Puerto F								4. Race White	, etc.	an Indian, Black,	
2 hours after "natural"	eted by	15. Decedent's Education (Specify only highest grade and Elementary/Secondary (0-12)  College (1-4)					completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						16b. Kir	nd of Bus				
21215-0036 uid be filed within 72 hours a: Mental Hygicoc. marked other than "natural c event, the Medical Examin	Completed	7 17. Father's Name (I						, e d d c					First, Middle	, Maiden S	urname)			
21215 uld be file Mental H marked c event, t	To Be	James Le								(Street a	and Numb	er or Ru	Ferne	umber, City	or Town		Zip Code)	
and 2 shou (ealth and N tem 27 is n traumatic		James L.		ard,	fathe		Ob. Place						on DC			City or	Fown, State	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Donation 5	X Cremation	pecify:	7	om State		ory or oth peak	erplace) e Cr	emato	ory	8/5/	2011	Be1	tsv	i11e	, MD	
Balt permit. Depart Import injury		21 igns are of contents Service Licenses MO1539  22. Name and Address of Facility Rapp Funeral & Cremate 933 Gist Ave. Silver Spring, MD 2091  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart												2091	0			
Physician Wedical		failure. List only	y one caus	on each	line.	aused the d			e mode o	f dying, si	uch as ca	rdiac or r	espiratory a	rrest, snoc	k, or nea	art	Approximate Interval Between Onset and Death	
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	niner	Sequentially list conditions, if any, leading to immediate  Clisease or injury that initiated  Due to (or as a consequence of):																
ecuted and transit	I Examine	events resulting in death) Last  Due to (or as a consequence of):  d.																
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certi	Be	25. Was case referr examiner?	ea to meaic		spital:	Inpatient 2	- FRIO	utpatient		6.Place o			Home 5	Residen	ra 6 w	Other	· Scene	
n of Viding Physical After this funeral dir	on: To	1 Yes 2 27. Manner of Death 1 Natural		ıding	28a Date		28b.	Time of Ir		8c. Injury	7	7 2	8d. Describ ubject sh	e how injur				
Division of Vital   Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certified in by the funeral director,	Certification	2 Accident 3 Suicide	Inv	estigation ald not be ermined	28e. Plac	2011 ce of Injury - residen	At home, fa	4 hrs arm, stree	t, factory		-	. 2	8f. Location or Town Simms Co	State)			ral Route Number, City	
			Certifying I	hysician	: To the be	st of my know	wledge, de					ce, and d	ue to the ca	use(s) and	manner	as state		
To the within To the comple	Medical	29b Signature and		а	nd manner					License							nth, Day, Year)	
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		30. Name and addre Donna M. V			ssistant	Medical E	xaminer		W. Bal	timore (	Street,	Baltim	ore, MD 2	21223				
S Regis	tate	31. Date filed (Mont	1201 Far	Den	32. R	egis <b>y</b> ar's Si	THE K											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25236 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:08 6 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner of Morriand Mad Saltimore If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign last birthday 8. Date of Birth **Funeral** ä Hours Min **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he provision once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** timore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 21230 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?
Yes 2 \( \sqrt{No} \) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates Black Completed 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Se College (1-4 or 5+) over Be 7. Father's Name (First ၉ 19b. Mailing Address (Street and Number or Rural R. 2421 Westport Street Informant's Name/Relationship (Type, isler-In Law 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Murial 2 Cremation 3 Removal from State cemetery, crematory 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service Lionsee 21. Signatu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pumonun disease or condition 00/20/12V Medical resulting in death) Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed plnods peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending 1 Natural 24 hours after death. Funeral Director: A Accident Investigation by the 1 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in Medical within 24 hour To the Fune completed fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29d. Date signed (Month, Day, Year) MD 16999005 22 , 2011 son who completed cause of death (Item 23a) (Type, Print) Regis

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Hugust **Physician** 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March6, 1938 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 🔀 M 2 🗆 F 214-36-2070 73 MD **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "marked". 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MD Baltimore Middle River Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21 Left Aileron Street 21220 USA Funeral 14 Bace - American Indian. Was Decedent Ever in U.S. Armed Forces?
 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 If Yes, Give Year or Dates: 1 Never Married 2X Married White 1 ☐ Yes 2 No Specify. Specify. ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Mechinist Ray Mechinist Co. 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Dorsey Catherine Buckler ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Left Aileron Street Balto. MD 21220 Gloria Buckler /wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 8/8/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave.Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final fai heart **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No P.O. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 2 No 3 Probably Munknown 1 Tes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 2 No 1 □ Yes 2 1410 1 Yes 26. Place of Death (Check only one) o Atter ding Physician: 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 24 hours after death. Funeral Director\* After Natural 2 Accident Injury 5 Pending investigation 1 Yes 2 No th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 \ Homicide To the Hospital or within 24 hours at To the Funeral D 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 5, 2011 RES-000 30. Name and address of person who completed cause of d. III 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Mor 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Brantner Physician/ Nonth ewis 4:00 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AA In stitute essub 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. A Strath Day Year 1941 Country) **Director** 70 234-62-3982 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location Director 1 Yes 2 X No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 7800 House of Correction Road 20794 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Construction 10 Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Allender Ethel Brantner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. BrantnerSr (brother) 175 Pysell Road #4, McHenry, MD 21541 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. 20a. Method of Disposition 20c. Location - City or Town, State Date 08 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) 2011 Signature of Euneral 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or domp shock, or heart failure. List only on ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate cause on each line Interval Between Onset and Death Immediate Cause (Final Se sician/ disease or condition resulting in death) Medical Due to (or a a consequence of): Examiner 4 youiz Sequentially list conditions. Examiner rany, leading to minisolate cause. Enter Underlying After this certificate has been signed by the attending physician and if uneral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? laidne 24a. Was an autopsy 1 Yes 2 No Yes 2 Be B 25. Was case referred to medical 26. Place of Death (Check only one) examinar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No Hospital ၉ Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 28d. Describe how injury occurred work? injury 5 Pending To the now, within 24 hours after ou. To the Funeral Director, After analysis of the filled in by the fi 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗀 only one)

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

Brock

00585

29d. Date signed (Month, Day, Year)

08-06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last)  $201^{\text{Year}}$ 11:10 P<sub>M</sub> AUGUST Physician/ RICHARD KEITH BALZANO Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner MONTGOMERY BETHESDA NATIONAL INSTITUTES OF HEALTH 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Days Hours July 21, Year 1964 Connecticut 047-66-6221 47 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland Hyglene.
I Hyglene.
I do ther than "natural", or items 23a or 28a-f sho a other than "natural", or items 23a or 28a-f sho avent, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State Director 1 X Yes 2 No West Haven Connecticut New Haven 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 06516 United States 80 Morris Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Appliance Company Manager Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Inportant: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) ၉ Shirley Gorry Peter Balzano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 80 Morris Street, West Haven, Connecticut 06516 Patricia Balzano/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment August 2011 North Haven, Connecticut All Saints Cemetery 22.Name and Address of Facility Cobert A. Pumphrey Funeral Home/ Chase. Inc. 2557 Wisconsin Ave., Bethesda, Maryland 20814-3501 Robert A. Pumphrey Funeral Home/ 21, Signature of Funeral Service Licensee M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph iin disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** COKONOKY ak Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events g physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 → Yes 2 □ No 24a. Was an autopsy performed? page 26. Place of Death (Check only one) 25. Was case referred to medical æ Other: 2 **29**No 1 Anpatient 2 ER/Outpatient 3 DOA 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 ANatural 5 Pending 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, within 2

> State Registrar

(Check

29b. Signature and title of certific

RACHEL

Ε. BEARD 31. Date filed (Month, Day, Year) 32. Registrar's Agnature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

29c, License number 00071900 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25240 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:52AM Drunson 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/ABattimound Mid **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 062305268 1 M 2 Months Hours (Month, Day, Year) **Director** Georgia Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore N/A 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3419 Bancroft Rd. 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Black Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Philanthropist years self Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ unk Naomi Camper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Brunson(son) 3419 Bancroft Rd., Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cem. 08/06/11 Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Hopiration disease or condition Medical resulting in death) r as a consequence of): Examiner ARDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) ed by the a detached f g Unknow signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify . Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 28d. Describe how injury occurred 5  $\square$  Pending work? Accident Investigation 2 No 24 hours after deat Funeral Director; completed filled in by the Suicide 6 🗌 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hos within 24 h To the Fur 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day,

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Ma	ıryland			nt of F te of E		and Me		giene <sub>Reg. No</sub>	2011	- 4	25241
Physician	1/	Decedent's Name (First, Middle, L     REYNALDO	.ast) BARRE	YRO						2. Date of Dea		<sup>y</sup> 201 Y <sup>ear</sup>		6:00 pm
Medica Examine		4a. Facility Name (if not institution, g				4b. City	, Town, or					. County of Deat	th	
Funeral		<b>2912 E. PR</b> 5. Social Security Number 6	. Sex 7. Age		st birthday)		er 1 Year		er 24 Hrs. 8	B. Date of Birt	th	N/A	thplac	e (State or Foreign
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Baltimore, oemit. Page 1 and Department of Hea Important: If item any injury or other	1	4 ☐ Donation 5 ☐ Other (Special Service Lice		AG.	LIPAY				3/17/ LER II			RAL HO		
<b>m</b> 88 5 6 6	4	23a. Part 1. Enter the disease, or co	omplications that caused	the death	1	<u>901</u>	<u>EAS</u>	TER1	N AVE	NUE,B	ALT	IMORE,	MD	21231
Pnysician/		shock, or heart failure. List onl Immediate Cause (Final disease or condition	y one cause on each line.				cina				,		Int	terval Between nset and Death man + h S
Medical Examiner		resulting in death)	Due to (or as a											77,000
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the total or the funeral director, page 2 should be detached for use as the total or the funeral director.	Completed by	tu menay	embolus							24a. Was auto perfo 1 \( \sum \) Yes	psy ormed?	prior to death?	comp	findings available etion of cause of
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e Hospi 124 hou 9 Funer: leted fill	Medical	(Check 2 Medical Exa	hysician: To the best of naminer: On the basis of extended the basis of extended the basis of th	amination	and/or inves	tigation, in	n my opinio	on, death	occurred at th	ne time, date a	and place	e, and due to the	cause	(s) and manner stated
To the comp		29b. Signature and title of certifier			MV		c. License	e number			29d. Da	ite signed (Mont	h, Day	Year)
		30. Name and address of person wh	no completed cause of de	ath (Item		Print)	DO(	5 8 8					20	011
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State Registra	_	31. Date filed (Month, Day, Year) AUG 0 9 2011	32. Registrar	s Signati	park	1								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25242 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:30 AM Sylvia Cooperman 2011 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Bedford Court If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth **Funeral** Months 1 □ M 2 💢 F 97 381-01-0327 June Poland **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director be notified Silver Spring 1 Yes 2 X No Montgomery Maryland ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20906 3701 International Drive **USA** filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White "natural" Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unk Ida Barman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 14828 Rocking Spring Drive Rockville, MD 20853 Melvin B. Cooperman, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 08/09/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. <sup>22. Name and Address of Facility</sup>
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Years shock, or heart failure. List only one ca Immediate Cause (Final Ph\_sician/ Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to or as a consequence of: that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 as the use 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No or Attending Physician: The law requires that the death Year Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Hospital 2 No Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: T, the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or but stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Programme To the basis of my knowledge, Vertill occurred at the time, date and place and due to the cause(s) and manner stated. 29a. Certifier

Records, Division of Vital To the Hospital of within 24 hours are To the Funeral Completed filled

Registrar

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State

DHMH 17 Rev 7/2009

30. Name and a

Benjamin

29b. Signature and title of certifier

Avrunin,

Date filed (Month, Day, Year)

MD

of person who completed cause of death (Item 23a) (Type, Print)

18111 Prince Philip Drive #209

29c. License number

D08381

29d. Date signed (Month, Day, Year)

August 8, 2011

Olney, Maryland 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 2. Date of Death 0.6 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ AUGUST 20°1′1 05:30 A M JUNE B. COLBERT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY ROCKVILLE SHADY GROVE ADVENTIST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) . Social Security Number Funeral 1 M 2 K CountryNJ Months Days Hours 0870741925 158-14-3340 85 Yrs. Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Examiner must be notified 1 Yes 2 No MT. AIRY HOWARD MD 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21771 18025 SHAFFERS MILL ROAD "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify Completed 3 X Widowed 4 Divorced WHITE injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other trainmast. HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SIMON **ELLA ABRAHAM** JOSEPH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18025 SHAFFERS MILL ROAD, MT. AIRY, MD 21771 ELLEN KING/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 08/08/2011 WOODBRIDGE, NJ BETH ISRAEL CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, BALTIMORE, MD 21208 Part 1. Enter the disease, or complications that caused shock, or heart foliure. List only one cause on each line. Immediate Cause (Final ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Physician/ pulmonar disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury piration that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 4 Pregnant
9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No has 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes ၉ 1 XInpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to mpleted filled in by the funeral 1X Natural (Month, Day, Year) 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number , MD D0067512 Anaust 6, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rocki, 11e 9901 Medical Ctr Dr

State Registrar Bangalore

MD

Madan

31. Date filed (MoMh, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 9:05 AM August 8, Year 011 Edward Anthony Collins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Baltimore Parkville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday, **Funeral** Days Aug 15, Year) 1915 1 K M 2 F 95 Months Pennsylvania 178-10-4355 Director Z Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at the Maryland Director 1 Yes 24 No MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21234 United States 8820 Walther Blvd or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give 1 Yes 2 No Specify. Specify "natural", Year or Dates. WWII White 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Citgo Cargo Expeditor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nora Catharine Hannigann George Edward Collins and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Collins /Son 339 Morton Rd. Essex, MD 21221 f Health or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aug permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2011 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives M01443 8717 Green Pastures Drive Towson Maryland 21286 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part 1 Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Prysician/ disease or condition resulting in death) presmonio Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner July to for as a ponsequence of as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Por Pregnant at time of death been signed by the s Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Division of Vital Records, Discare: 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an fire. Ila hom autopsy has performed this certificate 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 28d. Describe how injury occurred Certificate: To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 7 to the 29b. Signature and title of certifier 158646 mond 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar Ither

8800

Boulevard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 5.15 P M Dolores Catherine 2011 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death IMASHINGTON MEDICAL ARUNDE NER Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □ M 2 🗓 F Days Director (Month, Day, Year) 11/28/1933 213-30-4875 MD 77 Usual Residence of Decedent f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes X No Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? Funeral 903 Hollybrook Court 21061 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Office Manager Mortgage Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ is marked Gustav Mox Helen Anna Martin 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trau 903 Hollybrook Court Glen Burnie, MD 21061 Mrs. Francine Armstrong Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. 08/08/2011 Baltimore, MD Sonature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Pregnant at time of death Month Day Year 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law 124 hours after death.
Funeral Director: After this certificate has I autopsy performed death? Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗹 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work?
1 Yes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat Date signed (Month, Day, Year) 1345149 person who completed cause of death (Item 23a) (Type, Print) MOCRITAL 31. Date filed (Month, Day, Year, 32. Registrar's Signatu State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25246 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 3,2011 Physician/ Dolores B. Canoles 0:40P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Balto. Parkville OakCrest 6. Sex 7. Age (In vrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Months Hours Min April 8,1927 235-38-6008 West Virginia Director Usual Residence of Decedent 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Parkville 1 Yes 2 X No Balto. Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 8800 Walther Blvd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No White Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me ones. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Secretary pro Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary E. Matheny Jacob G. Bock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9421 Gunview Road Nottingham, Md. 21236 DTR. Mary A.C. Strassner Baltimore, 20a. Method of Disposition
1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 8-12-2011 Balto.Md. 4 ☐ Donation 5 ☐ Other (Specify) 0aklawn Schimunek FuneralHome 21. Signature of Fundal Service Lic 22. Name and Address of Facility Nottingham, Md. 9705 Belair road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ SCVD Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Yes 2 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 si autopsy perform Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending Accident
Suicide Investigation after death Director; / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The state of the cause of the cau Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. or by one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, alice m Brances 40 # RC67343 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 Watther Blud Parkrille, MD 21234 CRNP Alice BRAZIER 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25247 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Chappell Physician/ Month 08 Olay Virginia 20 Î 1 4:40p. M **Emma** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Essex Riverview Nursing Home . Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year, 1 🗆 M 2 🗔 🛪 213-26-9722 **Director** 05 MD 79 Usual Residence of Decede 28a-f show 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a, State 10b. County with the Maryland Director Edgewood 1 Yes 2 XNo Harford MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21040 509 Arum Court death items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Was Deceuent Armed Forces?

1 ☐ Yes 2 📈 No Examiner Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Black 3√ Widowed 4 □ Divorced 'natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12)
12th grade University Of MD Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of မ Emma Macklin Page 1 and 2 should be Sylvester Stanton traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
509 Arum Court, Edgewood, Md 21040 19a. Informant's Name/Relationship (Type, Print) Department of Health as Important: If Item 27 is any injury or other tracence. Denise Glascoe-Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Md Owings Mills, Garrison Forest Vet 8/5/201 Donation 5 Other (Specify) Signa 22. Name and Address of Facility March F/H West of Funeral Service License 21215 Wabash ave, Baltimore, Md 4300 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transit and resulting in death) Last physician s the burial Physician/Medical that the death certificate be P.O. Box 68760 as ding IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 month Year Pregnant at time of death Month Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of 24a Was an prior to completion death? has performed 2 No this certificate 1 Yes Yes 2 I or Attending Physician; after death.
Director: After this certifica Division of Vital 25. Was case referred to medical 26. Place of Death eck only one Certificate: To Be examiner? Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 - Residence 6 - Other (Specify) funeral ( 28a. Date of injury (Month, Day, Year) 27. Manne f Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Viatural 5 Pending 1 Yes 2 No Accident Investigation filled in by the 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined lospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) 8-3-11

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

2 Mares Pla

Dundalk M1) 21222

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2 0/1 dden 1:45 PM Medical Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner 4b. City. lizabeth Saltimore WYSING Center last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex Social Security Number 220–20–0214 Funeral Months Hours 1 🗆 M 2 🛣 F (Month, Day, Year 9/26/26 MD **Director** Usual Residence of Decedent 10c. City, Town or Location Baltimore 28a-f show 10b. County N/A 10d. Inside City Limits aţ 10a. State Director MD event, the Medical Examiner must be notified 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21227 3302 Benson Avenue Funeral 23a items ; 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces Black, White, etc. ō þ 1 X Never Married 2 ☐ Married 1 Yes : 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: WHite "natural", Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 12 Manufacturing Bookkeeper Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname)
Margaret B. Fallon 17. Father's Name (First, Middle, Last, Thomas J. Cadden 19a. Informant's Name/Relationship (Type, Print) Nancy A. Blair / Sister 9b. Mailing Address (Street and Number or Bural Route Number, City or Lown, State, Zip Code) 1458 Andre Street, Baltimore MD 21230 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State New Cathedral Cemetery 8/11/2011 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Doda, Jr. 22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 Sin Fure of Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a contequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying demic burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 phys the l attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No mcer Spine 1 🗌 Yes 3 Probably 4 Unknown Completed me 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy perform Yes 2 No 1 Yes 2 No After this certification 25. Was case referred to medical examiner?
1 ☐ Yes 2 🎢 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending death. 2 🗌 No Accident Investigation within 24 hours are r decti To the Funeral Director... completed filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 2 2011 30. Name and address of person who completed se of death (Item 23a) (Type, Print) 3320 Mar Vomo

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-05800 State of Maryland / Department of Health and Mental Hygiene Lee Carter Davidson, Jr. 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Lee Carter Davidson, Jr. 1406 hrs August 2, 2011 **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Harford Havre de Grace 105 Northway If Under 1 Year If Under 24Hrs. 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Country) Maryland Months Days Hours Director 36 October 06, 1974 213-80-8090 1 X M 2 F Vrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 X No Maryland Harford Havre de Grace 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho are it frem 27 is marked other than "natural", or items be notified at once. Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 105 Northway 21078 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces' 2 X No Yes White If Yes, Give Year Yes 2 X No specify: Specify: Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d other than the Medical Baltimore, MD 21215-0036 Food Service 12 Cook 1B.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lee Carter Davidson, Sr. Sandra Creswell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Northway, Havre de Grace, Maryland 21078 Lee Carter Davidson, Sr. (Father) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Burial 2 X Cremation 3 Removal from State Evans Funeral Chapel August 07, Forest Hill, Maryland 2011 Donation 5 Other Specify: Bel Air 21. Signature of Funeral Service Licensee Jeffrey R. Testermer 22 Name and Address of Facility Evans Funeral Chapel & Cremation Services — Bel Air (MO1543) 3 Newport Drive, Forest Hill, Maryland 21050 PARTI. Exter the disease, or complication failure, but only one cause on each line. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and Mudent Death a Cardiomegaly with biventricular hypertrophy and dilatation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical AMENDED 23a, pt.II, 27, per me, g919 9-28-11 sm X UNPENDED attending physician or use as the burial -Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal death Day 3 Ectopic pregnancy Month Year Live birth past 12 months? Pregnant at time of death 5 Other (Specify) signed by the att 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 臽 1 Yes 2 No 3 Probably 4 V Unknown Myocardial fibrosis and fatty liver, wolf-parkinson-white Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy syndrome this certificate has death? performed? page 2 1 🗸 Yes 2 No 1 ✓ Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes 2 28a. Date of Injury (Month, Day, Year After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 X Natural Yes 2 No 5 Pending after death. 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2Bf. Location (Street and Number or Rural Route Number, City Could not be Suicide within 24 hours aft To the Funeral Di completely filled in (Specify) Homicide 29a. Certifier 1 [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one)

State Registrar

31. Date filed (Month, Day, Year

Theodore M. King, Jr., MD.

e and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 2. Registrar's Signature

29c, License number

O.C.M.E.

DOME

29d. Date signed (Month, Day, Year)

August 3, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 1:05 pM **Physician** Tulor Davis August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Kensington Nursing & Rehab Kensington Birthplace (State or Foreign Country)
 T7 A Date of Birth (Month, Day, Year) 9/13/1923 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🗓 F VA 87 578-26-0964 Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c, City, Town or Location 10h County r 28a-f show notified at 1 Yes 2 No Director Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or USA 20011 434 Oneida Pl. NW Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. I ☐ Yes 2 🔀 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black If Yes, Give Year or Dates: 9 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) the Medical Government College (1-4or 5+) Elementary/Secondary (0-12) Printing Office Book Binder other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be (Unk.) Ferdinand Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 104 N. Oak St. Falls Church, VA 22046 Edward Beck, guardian 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 ☑ Premation 3 ☐ Removal from State Beltsville, MD 4 Donation 5 Other (Specify) Chesapeake Crematory 8/6/2011 22. Name and Address of acility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral M01539 933 Gist Ave. Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lerebrovesculer chillent **Physician** /Medical Due to (or as a consequence of): Examiner Dementic Sequentially list conditions, it is a sequentially list conditions, it is cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ysphe 11= the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Year in the past 12 months
1 ☐ Yes 2 ☐ No ned by the a detached for 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' 2 No 2 🛅 1□ Yes Division or Vital director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21-1No 1 Inpatient 2 ER/Outpatient 3□ DOA 1 ☐ Yes P funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner death Certification: e Hospital or Attending P 24 hours after death. e Funeral Director: After t etely filled in by the funera (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00064624 08/03/2011

State Registrar

SHARMA

32. Registrar's Signature 3. par

743

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUMMER

WALK DR. GATTHERSBURG, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 14:15 2011 August 6, LEO DALY, JR WILLIAM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical CENTER Towson If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F MD 67 30 1943 220-42-9974 Dec. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Owings Mills MDBaltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "matural", or items 230 or once. USA 9534 Georgian Way 21117 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 ☐XNo Specify: Specify: à 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Transportation 12 Logistics Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Emma Hein William Leo Daly, Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6808 Peters Path, Colleyville, TX 76034 Kevin W. Daly/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 8/11/11 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens 4 Donation 5 Other (Specify) Timonium, MD Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 8igna we Approximate Interval Between Onset and Death 23a. Part1. Ep er the lisease, or complication, that laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r heart fullure. List only one cayse on each line. Immediate Lause (5 al disease or resulting in death) minutes **Physician** Cardiac arrest /Medical Due to (or as a consequence of): **Examiner** unknown Aortic aneurysm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed years Hypertension and Due to (or as a consequence of) physician a the burial-1 Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1₩ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ☑ ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1X Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu investigation 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8/8/2011 D47221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

McDowell, M.D., 6701 N. Charles St., Baltimore, Maryland Philip R.

32. Registrar's Signature

11-05685 Thierno Poreco	Dial	Please Type or Print in Black Indelible  State of Maryland / Department			-	0505							
i v		1- For State Certificate		_	Reg. No.	2525							
Physicia	an/	Decedent's Name (First, Middle, Last)		2. Date of De Month		3. Time of Death							
Medical Exami	ner	Thierno P. Diallo 4a. Facility Name (if not institution, give street and number)	Lu ar si i i i i i i i i i i i i i i i i i i	July 29,	2011	1929 hrs							
4		7611 Willow Road	4b. City, Town, or Location of Deat Frederick	h	4c. County of Deat Frederick	n							
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr	s. B. Date of E	Birth (MM/DD/YYYY) 9. Bi	rtholace (State or							
Director		617-78-7441 1 M 2 F 47	Months Days Hours Min		23/1963 Forei	<sup>gn</sup> Conakry Guinea							
Aug		10e. State 10b. County 10c. City, Town or Loc	cation			10d. Inside City Limits							
and show	ь	MD Prince Georges Bowie				1 Yes 2 X No							
eath with the Maryland items 23a or 28a-f show ust be notified at once.	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou	intry?							
h the		4209 Hattits Progress Drive	20720		Africa								
th wit	Funeral		Nas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert		No- 14. Race - Amer White, etc.	ican Indian, Black,							
er dea		1   Yes 2   A   No	Yes 2 X No specify:		Specify: Bla	ack							
urs afi	ğ	or Dates:	ent's Usual Occupation (Give kind of	work done	16b Kind of Business/	Industry							
72 ho	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use re	tired)	Virginia Company	Water							
vithin ene.	Completed	12th Masters Deg. I	nician										
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	ပို	17. Father's Name (First, Middle, Last) Oumar Bela Diallo	18.Mother's Nam Maimou		o, Maiden Surname)								
212 ald be Menta marke	To Be		ing Address (Street and Number or			Zin Code)							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once.	-		9 Hattits Prog										
e, No. 1 and Health item			osition (Name of cemetery,	Date	20c. Location - City or	,							
imore, Pages l an nent of Hea ant: If iter or other try		We Burial 2 Cremation 3 Removal from State crematory or other place) Family Plot    Conakry   Family Plot   Family											
Baltir permit. I Departme Importa	ı	21. Signature of Funeral Service Licensee 22	. Name and Address of FacilitMan	ch F/I	H 1101 E.								
E E E		Synette K- your A	ve. Baltimore,	MD 2	1202								
Physician /Medical	ı	23a. Part I. Érder the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.	r the mode of dying, such as cardiac	or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and							
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Diabetic Ketoacidos  Due to (or as a consequence of):	<u>is</u>			Death							
		Sequentially list conditions, b											
	ner	if any, leading to immediate Due to (or as a consequence of):	<del>.,</del>	-									
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76( ficate g phys	Š.	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth	Fetal death 3 Ectopic pregna		23d. Date of deliver								
Box 68760, e death certificate by the attending physic ed for use as the bur	<u>Cia</u>	past 12 months?  4 Pregnant at time of death	Fetal death 3Ectopic pregna Other <i>(Specify)</i>	aricy	Month I	Day Year							
COTCS, P.O. BOX 68760, law requires that the death certificate be execut has been signed by the attending physician and a should be detached for use as the burial - tra	Physician/Medical	1 Yes 2 No 9 Unknown 9 Unknown			f								
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duires quires signid pe				24a. Wa		topsy findings available							
COTC law re has be	Completed	<del></del>		auto		completion of cause of							
cian: The certificate	ပ္ပြဲ			1 Yes		es 2 No							
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rafter death.  **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	ď,	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatie	26.Place of Death (Check		Residence 6 🗸 Other	r: Scone							
Of Vi ing Physi After this	밝	27. Manner of Death 28a. Date of Injury 28b. Time of			how injury occurred	. Occino							
ion C tending eath. tor: Af	흵	1 Natural 5 Pending (Month, Day,Year) 2 Accident Investigation	1 Yes 2 No										
Divisipital or At ours after defent birect filled in by	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.	28f. Location or Town,	(Street and Number or Ru	ral Route Number, City							
Divisior Hospital or Attend 24 hours after death Fruncral Director: etely filled in by the 1	5	4 Homicide determined (Specify)		Or TOWN,									
품 <u>4 발 원</u>	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ (Check only one) 2 Medical Examiner: On the Pasis of examination and/or investig											
To the within To the complet	Se l	and marner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo.								
	-		O.C.M.E.		July 30, 2011								
W 9	ŀ	30. Name and address of person who completed cause of death (Item 23a)											
Brend OCNE		Mary G. Ripple MD. Deputy Chief Medical Examiner 90	0 W. Baltimore Street, Baltin	more, MD 2	21223								
Sta	-	31. Date filed (Month, Cert (Mear)) 9 201 (32. Registrar's Signature	parkel										
Registi	- 1.0												

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:42 PM Calvin Earl Donnelly Medical 4c, County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Hospita 9+ Agres
5. Social Security Number Baltimore Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, 92, Year) 1 **3** M 2 □ F Maryland Director 212-20-0039 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No MD Catonsville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21228 719 Maiden Choice Lane Apt. HR203 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 No δ Maryland 21215-0036 1 ☐ Yes 2 🐼 No Specify: If Yes. Give Specify: Il Hygiene. other than "natural", 3 Divorced White Completed WW II Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) **CPA** Accounting 12 Be be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental H မ Maude Elizabeth Heinze John Ambrose Donnelly permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic s  $212\overline{28}$ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Ruth 🔂 Donnelly / Wife 719 Maiden Choice Lane Apt. HR 203 Catonsville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore Crematory 8/8/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licens 21229 3620 Wilkens Ave. Baltimore, Maryland as 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ theumoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events and resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) 2 No To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗌 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA Certificate: To After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 254 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Sham Avenue 951 31. Date filed (Month, Day, Year) State AUG 0 9 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ ,2011 Helen C. Euker Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie Baltimore Washington Medical Center 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Feb. 4. 1 M 2 XF 94 212-01-0545 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b County 10a. State 10c. City, Town or Location with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 XNo Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 21401 852 Coachway 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filled within 7 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Home Maker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Clara Downs Vincent Connolly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 852 Coachway, Annapolis, Maryland 21401 Patricia King / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 08/06/2011 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one ca that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onset and Death Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) r as a consequence of): **Examiner** Sequentially list conditions, if any, reauling to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant Box 3 Fctonic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No or Attending Physician: The law requires 3 Probably 4 Unknown 1 Yes Division of Vital Records, cate has been siç ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 Yes 2 No မ 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Morse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a d title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De State of Maryland / De	partment of be 8/09/2011 de l'unicate of L	lealth and M <b>hb</b> Jeath	iental Hyg	iene 0		25255			
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	th		3. Time of Death			
	Medic Examin	al	Frances Elizabeth Edwards  4a. Facility Name (if not institution, give street and number)	4b City Town or	Location of Death	8	1 2 4c. County	O 1 1	2:25 A M			
	LAGIIIII	ei	12525 Whispering Woods Dr.	Ocean (	City		Worcester					
	Funeral Director		5. Social Security Number  213-12-3326  6. Sex 1 M 2 F 90  Yrs. last birthda.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 14	Year) ,1921	9. Birth Co <i>ur</i> Mar	place (State or Foreign ntry) yland			
and	show	lor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location					10d. Inside City Limits			
Mary	28a-f notifie	Director		City					1 ☐ Yes 2 🗗 No			
vith the	23a or st be r	eral [	10e. Street and Number 12525 Whispering Woods Dr.	10f. Zip Code 21842	2		10g. Citizen of USA	What Cou	ntry?			
<b>036</b> rs after death	Department or result and wentair hygiene. Important: if it is not seen 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No  If Yes, Give  Year or Dates.	3. Was Decedent of His If Yes, specify Cubar 1  Yes 2 No	n, Mexican, Puerto I		Blac	ce - Americk, White,				
Maryland 21215-0036	ene. than "natu ne Medical	Completed	(Specify only highest grade completed) (Gillementary/Seconday (0-12) College (1-4 or 5+)	cedent's Usual Occupa ve kind of work done d . DO NOT use retired) emaker	ation luring most of workin	ng	16b. Kind of B	ho1d				
land 2	ental Hygie ked other ic event, tl	To Be (	17. Father's Name (First, Middle, Last) Henry G VanWagenen	ANG. TO I	18. Mother's Name Cath							
Mary d2 should	atn and M 127 is mai er traumat		Henry G VanWagenen    Gathryn Bassford     Geraldine Pat Moler daughter   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Company									
nore	t: If iten		1 Burial 2 Cremation 3 Removal from State cemetery, c	sposition (Name of rematory or other place	e)	Pate	20c. Location	•				
Baltimore, permit. Page 1 and	Deparme Importan any injun once.		4 Donation 5 Other (Specify) Glen Ha  21. Signature (Fuperal Service Incense)	aven Cemete 22. Name and Addres 3111 Mount	s of Facility St	allings	Funera	al Ho	me P.A.			
) N	sician/ Medical aminer	,	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Arrythm  Sequentially list conditions	nter the mode of dying ive Heart	g, such as cardiac o				Approximate Interval Between Onset and Death			
Division of Vital Records, P.O. Box 68760 fo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	hysiciar the buria	edical Examiner	Ti any, feading to inmediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):									
). Box 687 he death certific	by the attending p tached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5	B	у			ate of deliventh	very Day Year			
ds, P.O. quires that the	s been signed by should be deta	ed by Pl	Part II. Other significant conditions contributing to death but not resulting in the		en in Part I.	23e. Did tot			he cause of death?			
Division of Vital Records, tal or Attending Physician: The law requires after death.	ate has be page 2 sho	Complet				24a. Was al autops perfor 1 \( \sum \) Yes	med?	Were auto prior to co death? 1 \( \sum \) Yes	ppsy findings available ompletion of cause of			
Vital hysician:	his certifi I director		25. Was case referred to medical examiner?  1	ient 3 🗆 DOA Othe	nce of Death (Check r: 4  Nursing Hor		ence 6 🗆 Oth	er (Specify	Y)			
on of ending P	The state	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day, Year) injury	/ work?		8d. Describe ho	w injury occurr	red				
JIVISION al or Attendi s after death	Directo		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	2	28f. Location (St. City or Town		er or Rura	l Route Number,			
the Hospita	To the Funeral D completed filled in	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinior	n, death occurred at	the time, date an	d place, and du	e to the ca	use(s) and manner stated.			
P P	100		29b. Signature and title certifier	29c. License	number - 000 9	318 2	9d. Date signe	d (Month,	Pay, Yaar) 2 4			
(	(f)		30. Name and address of berson who completed cause of death (Item 23a) (Type NHV 774W Mb - 38394	DURONT	(BLV)	8E7	BYVi	LLE	DE 1991			
	Stat Registra	_	AUG 0 9 2011 Registrar's Signature	arked		)			-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25256 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 2019 5:52 P M Joseph Evans, III James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Baltimore **Examiner** Towson Greater Baltimore Medical Date o. (Month, Day 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min 1 X M 2 □ F 25 **Director** Feb 1986 Maryland 215-11-6866 Usual Residence of Decedent 28a-f show Department of Health and Merital Hygiene, important: If item 23a or 28a-f shoi important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the M-dical Examiner must be notified at 10a. State 10b County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2X No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25 Northwood Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Solar Energy Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Evans. Jr. Michelle Donna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Donna G. Suess/Mother 12324 Cleghorn Road, Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Denation 5 Other (Specify) Atlantic Crematory 8/5/11 Glen Burnie, Maryland Bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road. Timonium. MD 21093 23a. Part 1. Inter the lisease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate ause (Findisease or resulting in http://www.ndisease.com/disease.com Ph sician/ pacteria Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 as 1 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo Pregnant at time of death 5 Other (specify) a Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Jas autonsy certificate 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manne Lat Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year,

Registrar

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State

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ MORE chae Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** tospita Mayland nosa (În yrs. last birthday) 59 Yrs. 8. Date of Birth Birthplace (State or Foreign 5. Social Security Number If Under 24 Hrs. **Funeral** Months Days Hours Min. Country) 6/1957/1952 1 **X** M 2 □ F **Director** 216-56-9519 Usual Residence of Deceden er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland Director Yes 2 No N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21206 4206 Raspe Ave. death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces?
1 ☑ Yes 2 ☐ No 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after Specify: Black 1 ☐ Yes 2 💢 No Specify: permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MD General Hospital Security Guard 12th N/A Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Dorothy James Harold Elmore Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Elmore-Mother 4205 Raspe Ave. Balto., MD 21206 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Arbutus Mem. Park 8/9/2011 Halethorpe, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility March F/H ll0l E. North Ave. Baltimore, MD 21202 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Jue to (or as a consequence of): Exam and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No De 25. Was case eferred to medical examiner?
1 X Yes 2 □ No 26. Place of Death (Check only one) Be Hospital: Other: ဂ္ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending injury 1 Natural Accident
Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Muss Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year) mmeckam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar 32. Registrar's Signature

Sommerkam

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 67715 Medical 4a. Facility Name (if not institution, give street and number, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth If Under 1 Year 6. Sex 1 X M 2 □ F If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Feb. 08, 1948 63 South Carolina Director 249-78-5026 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fine 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be a conce. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Harford Abinadan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3403 Tree Frog Ct. 21009 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 2 No 1965-Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 1967 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HVAC Systems Sheet Metal Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lin Scheard Peopy Felkel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ruth Dale Ferris (Spouse) 3403 Tree Frog Ct. Abingdon, Maryland 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State Evans Funeral Chapel Bel Air August 08, 2011 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) neral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
3 Newport Drive, Forest Hill, Maryland 21 21. Signate Jeffrey R. Testerman (M01543) 23a. Parl 1. En shock, or her the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between O set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) > Medical Due to (or as a c uence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury pue to for as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death 2 No page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope, performed 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 1 ☐ Yes 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar YA MOSYICON

MW.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25259 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month AUG. 1:40PM REV. JOHN WESLEY LINWOOD FORD 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK HOME CITIZENS NURSING Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Months 213-05-8078 mo. Director DNCIT Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director FREDERICK MD Yes 2 No WALKERSVILLE 10e. Street and Number 10g. Citizen of What Country? Funeral DISCOVERY BLUD 21793 8618 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Forces?
1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: BLACK 3 Widowed 4 Divorced If Yes, Give Year or Dates. [947 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry MINISTERY Elementary/Seconday (0-12) College (1-4 or 5+) TINISTER Be permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important If item 27 is marked oth any injury or other the contract of 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည FORD JAMES CARRIE STEWARI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8618 DISCOVERY BLUD WALKERSVILLE MD 21793 ALICE B. FORD (WIFE) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Aug5, FREDERICK Mb. BARTONSVILLE COM. COM. 4 ☐ Donation 5 ☐ Other (Specify) ROLLINS FUN. HEME 21. Signature of Funeral Service Licens 22. Name and Address of Facility Kollen raus Q. SOUTH ST FREDERICK MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year n signed by the a Id be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy yes 2 No **Director:** After this certificate I 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending work' 1 Tyes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signature and title of codific

Registrar
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State

npleted cause of death (Item 23a) (Type, Print)

8/6/110000 Baltimore, Maryland 21215-0036 Faulkner, David Division of Vital Records, P.O. Box 68760

		Plea	ase Type or P	rint in	Black I	Indelibl	e Ink	k. Enst	ıre A	II Copie	s A	re Leg	jible.		
		For State Registrar	State of I	Marylar		oartmen e <i>rtificate</i>			and M	lental Hy	gier Reg.	211		252	60
		Decedent's Name (First, Middle	e, Last)							2. Date of De	ath			3. Time of D	eath
Physicia Medic		David Allen Fa	ulkner							Month August	6.	<sup>Day</sup> 2011	Year	12:20	$A^{M}$
Examin	er	4a. Facility Name (if not institution						Location of	f Death			4c. County			
		Shady Grove Ad  5. Social Security Number			last birthday	Rock		e If Under 2	04 Hrs	8. Date of Bir		Monte		ry hplace (State or i	Famian
Funeral Director		212-54-3173	1 X M 2 □ F	62	Yrs.	Months	Days	Hours	Min.	Month, Da January	23 <b>,</b>	1949	Wash	untry) ington,	D.C.
land show d at	'n	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or L	ocation								10d. Inside City	Limits
/laryla 8a-f s tiffied	Director	Maryland Montg	OMETV	Ga	ithers	churo								1 🔀 Yes 2	2 🗆 No
the N 1 or 2	٥	10e. Street and Number	omery	1 00	A CHCI,	10f. Zip	Code				10g.	Citizen of	What Co	untry?	
h with ns 23( nust l	Funeral	148 Treehaven	Street			208	78				Un	ited	Stat	tes	
r item		11. Marital Status	12. Was Deceder Armed Forces ried 1 ☐ Yes 2	t Ever in U.	S. 13	. Was Deced If Yes, spec	ent of His Ty Cubar	ispanic Orig n, Mexican,	in? (Spe Puerto I	cify Yes or No- Rican, etc.)			e - Amei ck, White	rican In <b>d</b> ian, e, etc.	
permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Inpopratment of Health and Mental Hygiene.  Important: If tem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 ☐ Never Married 2 🔀 Mar 3 ☐ Widowed 4 ☐ Divorced	If Voc Cive			1 🗆 Yes 🔞	X No	Specify:				Specify	Whi	ite	
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ge 1 and tof F: If ite		20a. Method of Disposition 1   Burial 2   Cremation	3 Removal from Sta	. 1 /	comptant cri	oosition (Nameratory or of	har nlac	i		Date			•	Town, State	
iit. Pa urtmer ortant njury		4 Donation 5 Other (\$21. Signature of Funeral Service L		Cre	mator	ry ium, I	nc.							Maryland	
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Ph_sician/		shock, or heart failure. List of Immediate Cause (Final disease or condition			Acal	ny th	n T	0						Onset and De 40 min w	eath
Medical	0 48	resulting in death)	a. Due to (or a	s a conseq	uence of):	Tuf.	74000								
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th cert tendir	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1 ☐ Live Birt	n 2 🗌 Fet	al death 3	Ectopic p		;y					ate of del	*	
e deat the at hed fo	Physician/Medica	1 Yes 2 No	4 ☐ Pregnan 9 ☐ Unknow		death 5	Other (sp	ecify)					IVIC	onth	Day Ye	ear
hat th ed by detac		Part II. Other significant condition	ons contributing to death	but not res	sulting in the	underlying o	ause giv	en in Part I		23e. Did t	tobacc	co use con	tribute to	the cause of dea	ath?
uires t n sign ild be	ed by									1 🗆	Yes	2 🗆 No	3 🗌 Pi	robably 4 🗷 Ui	nknown
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The lar	mo:										psy ormed 2	?/	death?	completion of cause 2 $\square$ No	use or
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hysic this ce	ပ္	1 Yes 2 No				ent 3 🗆 DC		4 ∟ Nu	rsing Ho	me 5 🗆 Resi	dence	6 🗌 Oth	er (Spec	ify)	
nding F th. After 1	Certificate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident Investi			28b, Time injury	of 28	Bc. Injury work 1 🔲			28d. Describe	how ir	njury occur	red		
- Atter er des ector by the	ertifi	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Place of I	njury - At ho		treet, factory	office						er or Rui	ral Route Numbe	r,
oital or ours aft eral Dir illed in									_	City or To					
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2 ☐ Medical E	p Physician: To the best Examiner: On the basis o p Nurse Practioner: To t	f examinatio	n and/or inve	estigation, in r	ny opinio	on, death oc	curred at	the time, date	and pla	ace, and du	e to the	cause(s) and manr	ner stated.
To th withii To th comp	-	29b. Signature and title of certifier				29c.	License	number						n, Day, Year)	
			· Mi	)		0	2068	488			A.	lengral	6th 1	2011	
-		30. Name and address of person	who completed cause o	death (Iten	n 23a) (Type,	Print) Med	ica l	Cxr	Dr	Rock	v . 1	ا مرا	ND	2085	D
Stat Registra		31. Date filed (Month, Day, Year)	0 2011 32. Regis	trar's Signa	iture	had	1			Rock				المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية	

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g918 8-11-11 vt

			1- State of Mary Registrar		artment of Hea tificate of Dea		ntal Hygien Reg. N	ZUII	25261
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Gladys Gardne			A	agust c	year	3. Time of Death
	Examir	er	4a. Facility Name (If not institution, give street and number)  Johns Hopkins Bayview Medical Ce  5. Social Security Number 6. Sex 7. Age (In	nter ryrs. last birthday)	4b. City, Town, or Loca  Baltimore  If Under 1 Year   If U	Jnder 24 Hrs. 8.	Date of Birth	c. County of Death	place (State or Foreign
	Funeral Director		219-30-0225 1 M 2X F 79  Usual Residence of Decedent		Months Days Ho		(Month, Day, Year) 11–15–19		MD
	Maryland I-f show ied at	tor	10a. State 10b. County 10	BALTIMOR					10d. Inside City Limits 1  Yes 2 No
	th with the 23a or 28s st be notif	al Director	10e. Street and Number  111 FLEMING DRIVE	DALTIHOR	10f. Zip-Code <b>21222</b>		10g. C	Citizen of What Cou	•
336	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Nowled 4 Divorced  12. Was Decedent Ever Armed Forces?  1 Yes Now If Yes, Give Year or Dates:	1	Was Decedent of Hispar If Yes, specify Cuban, Mo 1 ☐ Yes 2▼ No Sp	nic Origin? (Specify exican, Puerto Rica pecify:	Yes or No- n, etc.)	14. Race - Ameri Black, White Specify: <b>B</b> ]	
21215-0036	within 72 hou iene. • than "natura he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give life. L	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of working	Ť	Kind of Business/I	
	e filed with al Hygiene. other thar rent, the M	Be Co	12   17. Father's Name (First, Middle, Last)	KEY	PUNCH OPER	ATOR Mother's Name (Fi		BALTIMORI en Surname)	E CITY
Maryland	2 should be f and Mental H Is marked ot aumatic ever	일	LEE GREGORY  19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and i		BOOKER oute Number, City	or Town, State, Zi	p Code)
	and 2 seleath ar m 27 is		EDITH BEASLEY /DAUGHTER		6322 SHORT				
Baltimore	Pages 1 nent of H nt; If Ite ny or ot		20a. Method of Disposition  1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren ST. STAN	natory or other place)	08/11/		Location - City or 1	own, State
Balti	permit. Pages 1 and 2 Department of Health s Important; If Item 27 Is any Injury or other tra		21. Signature of Funeral Service Licensee		2. Name and Address of 1701 LAUR	Facility <b>JAM</b>	ES A. MO	RTON & SO	ONS F.H. INC
8760,	Cate be executed / Medical Examiner sthe burial-transit	edical Examiner		tory forsequence of: onary onsequence of: enous	, ,	, ~	sspiratory arrest,		Approximate Interval Between Onset and Death 2 days
P.O. Box 687	t the death certifi by the attending tached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions contributing to death but n	Fetal death 3 = e of death 5	Ectopic pregnancy Other (specify)	n Port I	22a Did tohaco	23d. Date of deli Month	very Day Year
	w requires that been signed be should be de	ed by	Part II. Other significant conditions contributing to death but h	ot resulting in the t	andenying cause given i	n Pan I.			obably 4 Unknown
Il Records,	The law rec ate has beer page 2 sho	Completed					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of 2   No
of Vital	ling Physician; Th. n. After this certificate funeral director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient	2 ☐ ER/Outpatien	Othori	Place of Death (Cl		6 ☐ Other (Spec	ify)
Division o		Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Yea  5 Pending investigation 5 Could not be determined  28e. Place of injury building, etc. (S	At home, farm, stre	M 1 ☐ Yes	2 🗆 No	Describe how in  Location (Street City or Town, Sta	and Number or Ru	ıral Route Number,
	To the Hospital or Attend within 24 hours after deatl To the Funeral Director	Medical Ce	29a. Certifier (check only one)  1 Certifying Physician: To the best of mm 2 Medical Examiner: On the basis of examiner and manner stated	amination and/or in	n occurred at the time, d vestigation, in my opinio	late and place, and on, death occurred	due to the cause at the time, date	e(s) and manner as and place, and du	s stated. e to the cause(s)
	vithir To the comp	Me	29b. Signature and title of certifier		29c. License nun			Date signed (Month	
	0		30. Name and address of person who completed cause of death  JEMILAT BADAMAS  31. Date filed (Month, Day, Year)  32. Registrar's	M.D.	2	4940 Eas	tern Aven	ue, Baltimo	ore, MD, 21224
	Sta Registr		AUG 0 9 2011	A. for	Kel				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Day 2011 August 4b. City. Town, or Location of Death 4c. County of Death Harford Forest Hill 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) If Under Year) 1919 1 □ M 2 🏻 F 92 Hours (Month, Day, Sept. 03, Months 10h County 10c. City, Town or Location

State
Registrar 1. Decedent's Name (First, Middle, Last) Physician/ Martina M. Goetzinger Medical 4a. Facility Name (if not institution, give street and number) Examiner The Senator Bob Hooper House 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Director Baltimore, MD 213-05-6027 Usual Residence of Decedent shov 10d. Inside City Limits 10a. State notified at Director 28a-f 1 ☐ Yes 2 🛛 No Bel Air Maryland Harford 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral U.S.A. Bel Air 212 A Crocker Dr 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces? Black, White, etc. ŏ þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Chntinental Can Company 8 other permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, 1 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rose Schunter Henry Means 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia Maans (Sister-in-Law) 212A Crocker Dr. Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 12. cemetery, crematory or o 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 f Funeral Service License 22. Name and Address of Facility
Evans Funeral Chapel & Cremetion Services — Bel Air Jeffrey R. Testerman Celegral 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examine Due to (or as a consequence of). that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last IE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown be detached for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Records, completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performe After this certificate 2 🗌 No 1 ☐ Yes 2 No 1 Yes the Hospital or Attending Physician: Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 \( \sum \) Yes 2 \( \sum \) No Other: 6 Other FORMICE 4 Nursing Home 5 Residence Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA of 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check crtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature a 29d, Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day Physician Hilwar 03 2011 August Operi /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Balt more
If Under 1 Year If Under 24 Hrs. Baltimore City YLOY 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) ocial Security Number . Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F Yrs. 77 Sept 23 1933 Director Maryland 219-28-7375 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Period Examines of the traumatic event, the Period Examines of the traumatic event, the Period Examines of the traumatic event, the Period Examines of the traumatic event, the Period Examines of the traumatic event, the Period Examines of the traumatic event of the traumat 1 XYes 2 □ No Directo Maryland Baltimore City Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 34 Poultney Street 21230 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status illed within 72 hours after 1X Yes 2 No If Yes, Give 1953-55 Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Clerk Food Distributor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be and Mental ပ Edwin A. Howard Nannie F. Fletcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) f Health a tem 27 is 605 N. Bentz Street, Suite 201 Frederick MD 21701 Michelle Martz Bowles - EXECUTOR 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ŏ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 5 Important: If any injury or once. Metro Crematory INC | 08-05-2011 | Baltimore, Maryland 22. Name and Address of Facility Cremation Society Of Maryland INC ignature of Funeral Service Licensee 299 Frederick Road, Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Crea Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of): Examiner The law requires that the death certificate be executed Latra Pentune

Due to (or as a consequence of): physician and the burial-trans that initiated events resulting in death) Last P.O. Box 68760, € Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 T I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Onknown should I Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has t irector, page 2 s prior to condeath? 1a Se 4 2 No 2 I No Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 N/No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Minpatient Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: ₽ 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 Reigol Resident AUGULT 03 Otl 1005 5. Handver 1t. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Enclashan Baltimore UMEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

AUG 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Elizabeth Lynne Haslup AKA Betsy August 4th 2011 2:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Center of Columbia Columbia Howard Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 T Months <sup>Year)</sup>1957 June 20 Hours 54 216-64-2695 **Director** Ohio Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carrol1 Marriottsville 1 ☐ Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11718 Route 99 **United States** 21104 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Restaurant & Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thromany injury or other trainmast. 12 Manager Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James J. Nickell Nancy Neeld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David P. Haslup / Husband 11718 Route 99, Marriottsville, Maryland 21104 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 5-11 Baltimore, Maryland 21. Signature of Euneral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sici n MULTIFOCAL GRONCHIOLOGINEOUAR CARCINOMA disease or condition resulting in death) YEARS Medical **Examiner** Sequentially list conditions r any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of, Exam resulting in death) Last Due to (or as a consequence of): sician ar burial-t Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 e attending physical for use as the k IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ Month Dav Year Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 → Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 XNo certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 **N**O Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 YOther (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of I Director: After to in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined within 24 hours are.

To the Funeral Dir Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar
DHMH 17 Rev 7/2009

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6336 CEDAR LANE COLLIMBIA, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 42011 02:55 AM HEROLD ust /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD ORIEN BELAIR BELAIR 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1**X**XM 2□ F Yrs. 1, 71 Nov. Maryland 216-36-9967 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 XXVo Director Harford Bel Air 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 310 Huntsman Court 21015 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∏Yes 2 ☐ No 1 Never Married 2 Married 1 ☐ Yes 2√TXNo Specify: White 2 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Appraiser Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph W. Herold, Sr. Ruth Tobin ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sandra Kerner (Daughter) 310 Huntsman Ct., Bel Air, MD 21014 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Atlantic Crematory 08/05/11 Glen Burnie, MD 4 ☐ Donation, 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeal Home, Bel Air 21. Signature Funeral Service Licens 610 W. MacPhail Road, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HEART FAILURE disease or condition resulting in death) CONGESTIVE /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ CARDIOMYOPATHY, ATRIAL FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HYPERTENSION, CHRONIC KIDNEY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a, Was an autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Examiner P.O. Box 68760, certificate be Records, Division of Vital

28a-f show

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Baltimore, Maryland 21215-0036

the burial-transit cate has been signed by the attending physician page 2 should be detached for use as the buria director, funeral To the Hospital or Attending within 24 hours after death. To the Funeral Director; After filled in by the

State Registrar DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DHANJANI SH 31. Date filed (Month, Day, Year) AUG 0 9 2011

(Check only one)

29b. Signature and title of certifier

622 S. UNION AVE, HAVRE DEGRACE, MD 21078

and manner stated.

CRIGINAL

29c. License number

D45344

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25266 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 0517 AM Percy Physician/ Lloyd Halterman Month 100 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Months Yrs. Maryland **Director** 38 Sept. 217-80-7633 Usual Residence of Decedent or 28a-f show 10b. County filed within 72 hours after death with the Maryland al Hygiene. Jother than "natural", or items 23a or 28a-f sho 10a State must be notified at 10c. City. Town or Location 10d, Inside City Limits **Funeral Director** Maryland N/S Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2820 Miles Avenue 21211 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 🙀 Married 1 ☐ Yes 2 😿 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐x No Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Independent Contractor Newspaper Delivery Be other traumatic event, permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Benjamin Franklin Halterman Youlanda Revnolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Youlanda Halterman Sister 3624 Ash Street, Baltimore, Maryland 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 8/7/2011 Glen Burnie, Maryland 21. Signature of Juneral Service License 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, 3031 Falls Road, Baltimore, Mar Pus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ulmonary disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner e5+1 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) bid Hospital or Attending Physician: The law requires that the death certificate be executed 105 Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No ၉ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 \square Yes 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

P.O. Box 68760 Division of Vital Records, in 24 hours after deam.
The Funeral Director: Aft

> State Registrar

29a. Certifier

(Check

only one)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

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Francisco A. Matheus, M.D. 13018 Georgia Avenue, Wheaton, Maryland 20906		,					,			-/		
				Francisco A. Matheus, M.			nue, Whea	aton, Ma	ryland	2090	5	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			, FOI	ryland / Depa			Mental Hy	giene	1 25268	
			State Registrar	Cer	tificate of E	Death		Reg. No. U		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Y	ar 3. Time of Death 10:00 PM	
-	Medic	al	Tse-Chao Alexander Huang  4a. Facility Name (if not institution, give street and number)		Ah City Town or	Location of Death	August	4c. County of		
	Examin	er	Manor Care - Potomac		Potomac	Location of Double		Montgo		
-	Funeral	1	5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	th 9	Birthplace (State or Foreign Country)	
	Director		579-70-3989 1 M 2 □ F	70 Yrs.	Months Days	Hours Will.	October .	Year) 11, 1940 Ch	ina	
	nd how at	١	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits	
	anylar a-f sl	ect	Maryland Montgomery	Gaithersbu	ırg				1 🎇 Yes 2 □ No	
	or 28		10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	at Country?	
	s 23a	Funeral Director	406 Watch Hill Lane		20899		1	United St	ates	
	death item ner n		11. Marital Status  12. Was Decedent Ev Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.	
36	after al", or xami	d by	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X N 3 ☐ Widowed 4 ☐ Divorced Year or Dates.	lo	1 ☐ Yes 2 🕱 No	Specify:		Specify:	Asian	
21215-0036	hours natur lical E	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation	liina	16b. Kind of Busin	ness Industry	
215	in 72 e. nan "ı	фшо	(Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5-4)	lifa D	kind of work done o O NOT use retired)	iuring most of worl	king	Í		
121	d with tygien ther th	a l	4	Engin	eer	40 Markhaula Nasa	no /Cinat Middle	Mining  Maiden Surname)		
anc	oe file antal F ced of	To E	17. Father's Name (First, Middle, Last)  Chia-li Huang					ing Chen		
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	19b. Maili				er, City or Town, Stat	te, Zip Code)	
Š	d 2 shaith a aith a 1 27 is ertrai		Susan Tung/Sister						Maryland 20878	
ore,	ge 1 an it of He if item or othe		20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cree	matani or other plac	e) Aug	oust 5,	20c. Location - C	ity or Town, State	
ij	ment tant:		4 ☐ Donation 5 ☐ Other (Specify)	Montgomer Crematori	um, Inc.	2	011	Bethesda,		
Baltimore,	permit. Page 1 a Department of F Important: If its any injury or of							l Home, Rockville,	ockville, Inc. Maryland 20850	
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	the death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death	
	Physician/		Immediate Cause (Final disease or condition resulting in death)  Pneumon:						Offset and Death	
199	Medical Examiner		Due to (or as a	consequence of):						
		Jer		consequence of):						
	uted d ansit	Examine	cause, Enter Underlying Cause (Disease or injury that initiated events  c.							
	exectian an		resulting in death) Last Due to (or as a	consequence of):						
09	ate be	Physician/Medical	d			<del></del>				
Box 68760	ertifica ding p	/Me	IF FEMALE: 23c. If yes, outcome of	of pregnancy	•		23d Date	23d. Date of delivery		
XO	atten atten for us	iciar	in the past 12 months?  1	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	СУ		Mont Mont		
. B	the de by the ached	hys	9 Unknown 9 Unknown							
s, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by P	Part II. Other significant conditions contributing to death but	at not resulting in the	underlying cause gi	ven in Part I.			ute to the cause of death?	
of Vital Records,	v requ	olete					24a. Was		ere autopsy findings available for to completion of cause of	
3ec	he lav tte hav	m o					perf	ormed? de	ath?	
ia.	<b>hysician:</b> The lav his certificate ha: I director, page 2	Be	25. Was case referred to medical examiner?			lace of Death (Che	ck only one)			
Š	Physic this co	ျ	1 ☐ Yes 2 🗶 No Hospital:  27. Manner of Death 28a. Date of injur	nt 2 ER/Outpatie		4 LX Nursing F		idence 6 Other		
n o	ding I. h. After funer	cate	1 X Natural 5 Pending (Month, Day, 2 Accident Investigation		work		26d. Describe	now injury occurred	'	
Division	Atten	Certificate:	3 Suicide 6 Could not be 28e. Place of Inju	ry - At home, farm, st	reet, factory, office				or Rural Route Number,	
Div	tal or rs afte al Dire		4 Homiciae aeterminea building, etc	. (Эреспу)			City or 10	wn, State)		
	e Hospit 24 hour e Funera aleted fill	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of only one) 3 Certifying Nurse Practioner: To the	amination and/or inves	stigation, in my opini	on, death occurred	at the time, date	and place, and due t	to the cause(s) and manner stated.	
	To the within To the Comp	2	29b. Signature and title of certifier		29c. Licens			29d. Date signed (		
			•			0054566		August 2	, 2011	
_			30. Name and address of person who completed cause of de			// 1 7		C	anviord 20002	
/	Sta	to	Sunitha Bhogavilli, M.D.,  31. Date filed (Month, Day, Year)  32. Registra	9801 Georg	gia Ave.,	#I-1/,	S11ver S	opring, M	aryrand 20902	
	Sta Registr		AUC 0 9 201	hans A	Back	0				

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 5, per fh. g924 2-7-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar 25269 Certificate of Death Reg. N 2. Date of Death 1. Decedent's Name (First, Middle, Last) . 2<u>011</u> Harrell 7 2:10 РМ K. Martha August 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Sandy Spring Friends Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F Months Davs Hours Min June 19, 1918 Kentucky 93 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1X Yes 2 ☐ No Rockville Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? United States 20851 403 Carl Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status rmed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) National Institute Elementary/Seconday (0-12) College (1-4 or 5+) of Pathology 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances L. Kline John B. Burdiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15201 Grey Fox Road, Upper Marlboro, Maryland 20772 Glenn T. Harrell, Jr./Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State August 17, Cheltenham Veterans Cemetery Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) วิก 1 1 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc.

Physician/ Medical Examiner

Physician/

Medical

10a. State

Director

Funeral

2

Completed

Be

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination.

To the Funeral Director: After this certific completed filled in by the funeral director,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	00.	300 West Montgomery Ave		Transplanta 20030 2003				
	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final		or respiratory arrest,	Approximate Interval Between Onset and Death				
	disease or condition	Endstage Renal Disease						
	resulting in death)	Due to (or as a consequence of):						
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):						
cal Exa	that initiated events c. resulting in death) Last	Due to (or as a consequence of):						
ledic	d.							
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	c. If yes, outcome of pregnancy  1		23d. Date of delivery Month Day Year				
ed by Ph	Part II. Other significant conditions cont	ributing to death but not resulting in the underlying cause given in Part I.		se contribute to the cause of death?				
complet			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No				
9	25. Was case referred to medical	26. Place of Death (Che	ck only one)					
To Be	examiner? 1 ☐ Yes 2 🔀 No	pspital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 💢 Nursing F	lome 5 ☐ Residence 6	Other (Specify)				
icate:	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)  28b. Time of injury  28c. Injury at work?  M 1 \( \sum \) Yes 2 \( \sum \) No	a. Date of injury (Month, Day, Year)  28b. Time of 28c. Injury at work?  28d. Describe how injury occurred					
Certif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	i Number or Rural Route Number,					
Medical Certificate:	(Check 2 Medical Examine	ian: To the best of my knowledge, death occured at the time, date and place, and on the basis of examination and/or investigation, in my opinion, death occurred Practioner: To the best of my knowledge, death occurred at the time, date and place.	at the time, date and place,	and due to the cause(s) and manner state				

29c, License number

D35579

29d. Date signed (Month, Day, Year)

08/201

08

DHMH 17 Rev 7/2009

State

Registrar

within 24 hours a To the Funeral C

29b. Signature and title of co

31. Date filed (Month, Day

AUG 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Susan J. Miller, M.D. 8218 Wisconsin Avenue, Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar 25270 Certificate of Death Reg. No 1 Decedent's Name (First Middle Last) 2 Date of Death Physician/ SALEM **JOHN** HADAD, JR. AUGUST 2011 12:10 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 701 KING FARM BOULEVARD #511 ROCKVILLE MONTGOMERY If Under Age (In vrs. last birthday) Year If Under 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Days MAY 18, 1924 169-18-9517 Hours 87 Director PENNSYLVANIA Usual Residence of Decedent show 10b. County 10a. State items 23a or 28a-f sho ner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND ROCKVILLE MONTGOMERY 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 701 KING FARM BOULEVARD #511 20850 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Yes 2 No Black, White, etc. 1 Never Married 2 Married ö ģ Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify "natural", 3 Widowed 4 Divorced Specify. Completed WHITE WW-I the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SELF EMPLOYED MEDICAL LAB other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o မှ SALEM JOHN HADAD, SR. SADIE MUNYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other LORRAINE G. HADAD/ WIFE 701 KING FARM BOULEVARD, #511, ROCKVILLE, MARYLAND 20850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State MONTGOMERY or other place)
CREMATORIUM INC. 1  $\square$  Burial 2  $\overline{\mathbf{X}}$  Cremation 3  $\square$  Removal from State AUGUST 9, 2011 4 ☐ Donation 5 ☐ Other (Specify) BETHESDA, MARYLAND ss of Facility ROBERT
E. INC. 300 V
E. MARYLAND PUMPHREY FUNERAL HOME/ MONTGOMERY AVENUE 0-2805 21. Signature of Fungal Service Li M00335 23a. Part 1. Enter the disease or shock, or heart failure. List of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ PROGRESSIVE SUPRANUCLEAR PALSY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Due to or as a consequence of: cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir Due to (or as a consequence of): resulting in death) Last burial Physician/Medical The law requires that the death certificate be Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No Unknown detached g Unknown P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CEREBROVASCULAR DISEASE Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ESSENTIAL HYPERTENSION 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No \_Yes 2**x** No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 **X**Vo Other: ၉ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 XResidence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 5 Pending hours after death. 2 🗌 No completed filled in by the I Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 3 within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD# ME 91750 **AUGUST 8, 2011** 

State
Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

ROBERT MARK KAISER, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25271 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month Year rarrison Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death edical N/A If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Min 61 Yrs Director 1949 Usual Residence of Decedent or 28a-f shov show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 XYes 2 No MD N/A 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 501 E. Preston St. Apt. 513 21213 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Black Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Disabled Disabled yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Moody Hughes Marie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda M. Garrett-Sister 4803 Tamarind Rd. Apt. 234 Balto., MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest 8/9/2011 OwingsMills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March 1101 E. North Ave. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate terval Between and Death Immediate Cause (Final 4 a and De Physician/ an disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** -au Sequentially list conditions, If any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or) Examir The law requires that the death certificate be executed MONTHS physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 nding puse as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 🗌 No g Unknown 9 Unknown PO Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? 1 ☐ Yes 2 ☐ No Yes the Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2**X** No Other: 1 Yes 욘 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28b. Time of Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending Accident Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ands

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day,

54

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 Year SBA M onald Keith 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Battimore N/A VA Medical Center Bathmore 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. Year) 951 219-56-9232 Yrs. MARYLAND Director 60 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural". or items 920 or 000 c - - -10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 217 S. CENTRAL AVENUE 21202 U.S.A. 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces? X Yes 2 □ No Black, White, etc. 1 XNever Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1969-73 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SELFCEMPLOYED AIR CONDITIONING 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marked any injury or other trans THOMAS KARL HETZ MARY VIRGINIA BURDOCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2816 MARY WILAND/ SISTER JANE LANE, HILLIARD, FLORIDA 32046 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 8/4/11 BALTIMORE, MARYLAND LTELY Adresz ETTER INC. 1901 EASTERN AVENUE FUNERAL HOME, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician, Due to (or as a con equence of): disease or condition CARDOLISM Medical resulting in death) **Examiner** Examiner if any, leading to immediate cause. Enter the denying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2.9 autopsy performe death? 2 No \_\_ Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 2 NO No Other: 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

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30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

1518285519

Bultmore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>D</sup>2/011 4:53 P. M Audust 5, Physician/ Florence Elizabeth Jubb Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number DeC. 4 1923 Funeral Days Hours Mar Tand 1 □ M 2 👽 F 87 218-14-5409 Director Usual Residence of Decedent 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Health and Mental Hygiene.

27 is marked outher than "natural", or items 28a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State Director 1 Yes 2 X No Bel Air Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Funeral 21014 1333 Saratoga Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Black, White, etc. White 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: Completed 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Secretary 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Emma Elizabeth Kratz ၉ Joseph Anthony Burkard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4945 St. Paul; s Church Rd. Pylesville, MD 21132 Florence Kestner / Daughter t of Health 20c. Location - City or Town, State 20b. Place of Disposition (Name of Aug. Date 20a. Method of Disposition Evans Funeral the Evans ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Page 1 Forest Hill, Maryland 5 Department of Important: If any injury or 2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service-BelAir 3 Newport Drive Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death CARDIOVASCUL AR Atherosclerofi Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be . 124 hours after death. e Funeral Director: After this certificate has been signed by the attending physicia Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 L. Feta God.

Pregnant at time of death Year in the past 12 months?

1 Yes 2 No
9 Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Medical Certificate: To Be examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 2 X No 1 Yes 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of completed filled in by the funeral 27. Manner of Death 5 Pending 1 📆 Natural Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29c. License number 29b. Signature and title of certifie 235522 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 2 NORTH AV 31. Date filed (Month, Day, Year) AIR

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ANd

11-05804 Margaret Jensvold Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 25274 Margaret Jensvold 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 2, 2011 Margaret Ferne Jensvold 1424 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery Kensington 8 Simms Court If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral oreign Country) NJ Min unk Months Davs Director 1 M 2 X F 54 8/5/1956 Usual Residence of Deceden 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 XXNo JS I can a source.

1 of Health and Mental Hygiene.

1 If item 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Medical Examiner must be notified at once. MD Montgomery Kensington Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 20895 USA 8 Simms Court Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No Yes White If Yes, Give Year 1 Yes 2X No specify: 3 Widowed 4 X Divorced <u></u> 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Health Psychiatrist Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Dean Jensvold Emily Ann VanIngen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Judy Citko, sister 1701 Olympus Dr. Sacramento, CA 95864 20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Chesapeake Crematory 8/9/2011 Beltsville, MD Department c Donation 5 Other Specify. MO1539 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Service License 933 Gist Ave. Silver Spring, MD 20910 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death a. Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown signed by the detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of performed death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) FOUND: After 28d. Describe how injury occurred Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject shot self \_\_ Natural FOUND: 1 Yes 2 ✔ No 5 Pending death. Director: d in by the Aug 2, 2011 1424 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 8 Simms Court, Kensington, MD determined (Specify) residence To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d, Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier O.C.M.E. August 3, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jul 30. 2011 5:55a M Albert Johnson, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A **Baltimore** Joseph Richey Hospice, Inc. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Hours Min. Country) MD 71 **Director** Aug 28, 1939 213-34-4647 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at within 72 hours after death with the Maryland Director 1 Yes 2 No **Baltimore** N/A MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 21225 2419 Terra Firma Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify. Black If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) n and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the **Factory Factory Worker** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charlotte Johnson Albert Johnson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 2419 Terra Firma Road Brooklyn, MD 21225 Janice Johnson 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date emetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Lansdowne, Maryland Aug 04, 2011 4 Donation 5 Other (Specify) Mt. Zion Cemetery 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 21. Signature of funeral Service Licen -21 23a. Part 1. Enter the disease, or complications that caused the shock, wheart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final Stomach cancer Ph\_sician/ months disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 Other (specify) Yes Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 2 X No certificate Yes 2 No 1 Tes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 X No ၉ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) HOS DICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at nours after death. neral Director: After the filled in by the funeral Certificate: 28d. Describe how injury occurred (Month, Day, Year) work?
1 Yes 2 No injury 1 Natural 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) City or Town, State) within 24 hours a To the Funeral Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying flutse Practioner: To you have a stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7-30-2011 D51788 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6115 Falls Rd #300 Baltimore MD Tim Polk MD. 32. Registrar ignature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 20

		1	For State Registrar	State of Maryla		ificate of D			Reg. No.			
	Physicia	n/	1. Decedent's Name (First, Middle, Shirley Ja	CKSON				2. Date of Dea Month	Day	Year <b>2011</b>	3. Time of Death 2309 P M	
	Medic Examin	er	4a. Facility Name (if not institution, g	give street and number)			Location of Death			ty of Death	I/A	
	Funeral Director		University of M 5. Social Security Number 217-24-9303		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Feb 1	h	g. Birth	nplace (State or Foreign ntry) MD	
	Maryland 8a-f show tified at	I - 1	Usual Residence of Decedent  10a. State 10b. County  MD Balti	more City	City, Town or Loc	ation	Baltimore				10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	with the ls 23a or 2	Funeral Di	10e. Street and Number 168 South Collins Av	enue		10f. Zip Code	21229		10g. Citizen o	f What Cou		
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates.		as Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. R B Speci	lack, White		
Baltimore, Maryland 21215-0036	vithin 72 hou jiene. er than "natu the Medical	Completed	15. Decedent (Specify only highes Elementary/Seconday (0-12) 12	's Education t grade completed) College (1-4 or 5+)	(Give k	Decedent's Usual Occupation     (Give kind of work done during most of working life. DO NOT use retired)     Homemaker			16b. Kind of	ndustry lome		
and;	be filed vertiled be filed vertiled by the control of the control	To Be	17. Father's Name (First, Middle, La	James P. Scott			18. Mother's Nan		Maiden Surna Mary Sco			
Mary	12 should be file alth and Mental H 27 is marked o r traumatic eve		19a. Informant's Name/Relationshi Tyrone Jones	p (Type, Print)	19b. Mailin	g Address (Street a outh Pulask	and Number or Rui i Street Balt	al Route Numbe imore, MD	r, City or Town 21223	, State, Zip	Code)	
imore,	Page 1 and ment of Hea ant: If item ury or othe		20a. Method of Disposition  1 🔏 Burial 2 🗀 Cremation 4 🔲 Donation 5 🗆 Other (Sp.	3 ☐ Removal from State pecify)	Loudon Park Cemetery			Aug 03, 2011		20c. Location - City or Town, State <b>Baltimore, Md.</b>		
Balt	permit. Depart Import any inj		21. Signative of cral Service Lie	censee Star	22.	Name and Addres Estep Br 1300 Eut	others Funera aw Place Balt	al Service, P imore, Md 2	1217			
	Physician/ Medical Examiner	ner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Due to (or as a cons b. Seven Due to (or as a cons	sequence of):  Sequence of):	vidoris vu		Approximate Interval Between Onset and Death				
3760	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director. After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last		c. Penpneral Vacular biseas  Due to (or as a consequence of):						10 des	
. Box 687	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No g □ Unknown	23c. If yes, outcome of pre 1  Live Birth 2  4  Pregnant at time 9  Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су			Date of del Month	ivery Day Year	
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Division of Vital Records,	The law re cate has be page 2 sho	Comple						24a. Was auto perf 1 🗆 Yes		prior to death?	topsy findings available completion of cause of	
/ital	/siclan: s certific director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	≥ ☐ ER/Outpatien	Oth	lace of Death (Che	ck only one) lome 5 ☐ Resi	dence 6 $\square$ 0	Other (Spec	ify)	
on of	nding Phy ath. TAfter thise funeral of		27. Manner of Death  1 X Natural 5 Pending 2 Accident Investig	28a. Date of injury (Month, Day, Year	28b. Time of	28c. Injur work	y at	28d. Describe				
Division	al or Atter s after des l Director d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi			eet, factory, office		28f. Location ( City or To	Street and Nui wn, State)	mber or Ru	ral Route Number,	
	ne Hospit in 24 houn ne Funera pleted fille	Medical	(Check 2 Medical E	Physician: To the best of my knaminer: On the basis of examin Nurse Practioner: To the best of	ation and/or invest	igation, in my opini	on, death occurred	at the time, date	and place, and	due to the	cause(s) and manner stated.	
	To the within 2 To the comple	-	29b. Signature and title of certifier	- M Shai	NX WI	29c. Licens			29d. Date sig	ned (Monti		
	7		30. Name and address of person v	vho completed cause of death (	(Item 23a) (Type, F	rint)			·····			
	Sta	te	Jevrurfev 31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature	greene	. St. Bo	LITIMOY	e, MI	) "H	201	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month August Physician/ 3:30 A M Jackson Dorothy 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Randallsotwn Seasons Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthdav) **Funeral** (Month, Day Year) May 30, 1927 Days Min 1 □ M 2 🗶 F Md 220-20-6430 84 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 No be notified **Baltimore** 28a-f MD **Baltimore City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Completed by Funeral 21216 U.S.A. 3309 Mondawmin Avenue Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. **Black** 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Lisual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Federal Government** Federal Employee 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nettie P. Scott ပ James E. Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 640 Hillview Road Brooklyn, MD 21225 Lelia E. Harrison 20a. Method of Disposition
1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Arbutus Memorial Park 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once. Aug 08, 2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service bicenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Renal End. Stage Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burial-t nding physician ause as the burial-Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗹 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 autopsy performe death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other Specify 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury e hoor in 24 hours after dea... the Funeral Director: After triad in by the fu Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MS RajapaneM.D 00057465

Registrar

DHMH 17 Rev 7/2009

State

Smith N

5-203

Bulhmore MD Z1209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5832

32. Registrar's Signature

Rajapakse, M.D.

AUG 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 25278 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Donald Thomas Kosak Physician/ 12:25 P.M August 201 ga Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore County Timonium Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. **Funeral** 5. Social Security Number 158–16–1547 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Days Hours June 28, Year 1926 85 New Jersey Director Usual Residence of Decedent 28a-f shov 10b. County within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Funeral Director be notified Maryland Harford County Joppa 1 🗆 Yes 2 🔀 No or Street and Numbe 10f. Zip Code 21085 10g. Citizen of What Country? 23a 572 B. Renee Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S Was Deceded 1944. Accord Forces? 1944. 1946 14. Race - American Indian, 1944þ Black, White, etc. 1 Never Married 2 Married 21215-0036 1 🗆 Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fireman's Fund ClaimsManager 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Caroline Rosivach 2011 Stefan Kosak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Important: If item 27 is any injury or other trau 3633 Jærettsville Pike, Monkton, Maryland 21111 Kristen Darwin (Daughter) Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeal Chapel 20c. Location - City or Town, State AUGUST 1 Burial 2X Cremation 3 Removal from State 08/09/2011 Forest Hill, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Evan Funeral Chapel & Cremation Services-BelAir 3 Newport Drive, Forest Hill, Maryland 21050 Scorn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) PANCREATIC CANCER Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): igned by the attending physician be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be eath hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 4 Pregnant at time of death Day Year Yes 2 No 9 Unknown 9 Unknown signed by DONALD KOSAK Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Tes 2 No 3 Probably 4 Number Funeral Director: After this certificate has been sisted filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 2 🗌 No 1  $\square$  Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUNECIA WHITE, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) -State

ORIGINAL

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25279 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7011 Physician/ Raymond Kesselman 9:30 A M August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE RANDALLSTOWN SEASONS HOSPICE @NORTHWEST HOSPITAL If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 D F Months Hours 0570871922 89 DC Director 216-18-4782 28a-f show 10d. Inside City Limits 10b. Count at 10a, State 10c. City. Town or Location Director Examiner must be notified MD **BALT IMORE** BALTIMORE 1 Yes 2 No 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? 23a Funeral USA 1840 REISTERSTOWN ROAD, #229 21208 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. "natural", or þ 1 Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 YNo Specify Specify WHITE Completed 3 Wildowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry Je filed wiu. ™tal Hygiene. ™r Than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) DAIRY MILKMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h ပ SARAH VINNICK **ABRAHAM** KESSELMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 600 MOUNTAIN ROAD, FALLSTON, MD 21047 MICHAEL KESSELMAN/SON 20b. Place of Disposition (Name of cemelon grounder) of other place)
BENEFICIAL CERCLE 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/07/2011 ROSEDALE, MD 21. Signatury of Funeral Service I 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. shock, or heart failure. List only one Onset and Death Immediate Cause (Final Cardicrascular Disease Physician/ Athenoscientic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Days to for as a ponecourage of cause. Enter Underlying Cause (Disease or iinjury Examir and trar that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death ☐ Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medica the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 26. Place of Death (Check only one) Be examiner? Hospital in patient hospice 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA ဂ္ 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined City or Town, State, 29a. Certifier ☑∕Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ms Rajapalne M 00057465 815/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimory MD. 21709.

DHMH 17 Rev 7/2009

State

Registrar

N.S. Rajapakte INIO

31. Date filed (Month, Day, Year)

AUG 0 9 2011

2835 Smith AV

32. Registrar's Signature

203

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12:05 AM August 7, Gilbert Grafton Keene Sr. Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 641 W. Kingsway Rd. Middle River Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 **≥** M 2 □ F 84 Janth, 135 Year 1927 Maryland 214-20-1088 Director Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland notified at Director 28a-f 1 Yes 2 No Baltimore Middle River 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? ō er than "natural", or items 23a of the Medical Examiner must be Funeral 21220 United States 641 W. Kingsway Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Food Industry Route Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h ည Herbert Keene Sara Elizabeth Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trat once. Jerry Keene /Son 641 W. Kingsway Rd. Middle River, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Aug 09 cemetery, crematory or other place) 1 🗆 Burial 2 Cremation 3 🗆 Removal from State Beltsville, Maryland Chesapeake Crematory 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final -Ph sician/ resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Dissito for as a nonsecuence offi signed by the attending physician and de detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? autopsy perform or Attending Physician; The To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pendina Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number

State Registrar

of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25281 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Year Physician/ August 1, KATHLEEN KEAVNEY 11:12 AM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Harford Bel Air Upper CHesapeake Med. Center 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Aug. 21, <sup>Year)</sup>1953 Months Hours ~Maryland 219-62-4134 57 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at notified 28a-f 1 Yes 2XNo Maryland Harford Bel Air  $\bar{\Box}$ 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or must be r Funeral 1002 Jessicas Court Apt A 21014 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4XXDivorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 Admin. Assistant College Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H If item 27 is marked ot r other traumatic ever မ Mary Ν. Fleming John C. Keavney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21014 1110 Red Pump Road, Bel AIr, MD Susan Sorrentino (sister) permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 3 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Atlantic Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/04/11 Glen Burnie, MD 21. Signative of Fun val Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Bel Air 610 West MacPhail Road, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHANIC OBSTAULTNO Pnysician/ Medical resulting in death) GACAPNOGIC RESIDENTALISM Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 1 Yes 2 No 9 Unknown Year Month 5 Other (specify) Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of the Hospital or Attending F thin 24 hours after death. the Funeral Director: After t Natural 2 Accider work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be ☐ Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUG 0 9 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23da Perf May 16918 Department of Health and Mental Hygien 20 | |

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Physici	an/	1. Decedent's Name (First, Middle, La	st) KIRKLAND					2. Date of Dea	Day	Year	3. Time of Death	
Med Exami		4a. Facility Name (if not institution, give					Location of Death	08	4c. County	2011 of Death	72 ZO W	
Funera Director		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last bird		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Feb.	th y, Year) 6, 1948	9. Birthp Coun Miss	place (State or Foreign try)	
yland f show	içi	Usual Residence of Decedent  10a. State  10b. County		10c. City, Tow	n or Loca	ation				1	0d. Inside City Limits	
death with the Maryland r items 23a or 28a-f sho ner must be notified at	Funeral Director	Maryland Carro  10e. Street and Number	11	Ma	nche	ster 10f. Zip Code			10g. Citizen of W	hat Cour	1 ☐ Yes 2XX No	
h with t ns 23a nust be	neral	3271 Charmil Driv				2110			10g. Citizen of W Unite of Am	d St eric	ates a	
	by	11. Marital Status  1 □ Never Married ¾X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Every Armed Forces?  1  Yes 2  Yes If Yes, Give Year or Dates.			as Decedent of H Yes, specify Cuba □ Yes ②XXNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	, White,	an Indian, etc. ite	
Z15-UU36 in 72 hours after e. nan "natural", on Medical Exami	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)			(Give kii	ent's Usual Occup and of work done o NOT use retired)	ation during most of wor	king	16b. Kind of Bu	siness Inc	dustry	
ZZZZ	Be	17. Father's Name (First, Middle, Last)	4			Social V		no /First Middle	State o		braska	
yiand ild be filed Mental Hy narked oth	10	George Phillip St	eele, Sr.					an Mae				
Mar 12 shou Ulth and 27 is m		19a. Informant's Name/Relationship (1) Sanford H. Kirkla		1	-		Dr., Man		· ·		Code)	
baltimore, permit. Page 1 and Department of Heal Important: If item 3 any injury or other once.		20a. Method of Disposition  1 ☐ Burial ※XX Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		20b. Place of All Fa	of Disposi ery, crema a i ths Char	tion (Name of atory or other place S Cremati Del	ory Au	g. 6, 2011	20c. Location -		own, State Maryland	
balt permit. Depart Import any inji		21. Signature of Final Single Licen	the.		22.	Name and Addres	es of Facility Ec	khardt :	Funeral	Chap	el, P.A.	
- Ph_sician/		232 Part I. Enter the disease, or com- snock, or heart failure. List only of Impodiate Cause (Final	one cause on each line.	the death. Do r		the mode of dyin	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death	
Medical Examiner		disease or condition resulting in death)	Due to (or as a		of):	ORG-AN F	AILURE				3 days	
rted d insit	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a			RY FAIL	URE / ACI	LTE KIDA	IEY INJU	RY	6 days	
ox oo loo	ical Examiner	that initiated events resulting in death) Last	Due to (or as a		of):				<del></del>			
ertificate ding phy se as the		IF FEMALE:	- u									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal deatl		Ectopic pregnand Other (specify)	у	· · · · · · · · · · · · · · · · · · ·			te of delivery onth Day Year	
requires that the decomposition by the isolated by the should be detached	2	Part II. Other significant conditions of	ontributing to death bu	it not resulting	in the un	derlying cause giv	en in Part I.		1		ne cause of death?	
Physician: The law requirer rthis certificate has been signal director, page 2 should	Completed							24a. Was autor perfo 1 \sum Yes	osy p		psy findings available mpletion of cause of	
/sician: s certifica director, p	Ba Ba	25. Was case referred to medical examiner?	Hospital:				ace of Death (Chec					
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or Attending frer death. irector: After by the fund	Certificate:	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not b		Year) i	injury 	M 1 🗆	? Yes 2 □ No					
LIVISI Ital or Att Ins after d al Direct led in by t		4  Homicide determined	building, etc.	(Specify)				City or Tow				
To the Hospital or Attendii Within 24 hours after death. To the Funeral Director: After Completed filled in by the tu	Medical	(Check 2   Medical Examonly one) 3   Certifying Nur	sician: To the best of n iner: On the basis of ex se Practioner: To the b	amination and/o	or investig	ation, in my opinic	n, death occurred	at the time, date a	ind place, and due	to the ca	use(s) and manner stated.	
With Con		29b. Signature and title of certifier    Auck Val	in, MD CP	HYSICIA	tu)	29c. License	onumber 6514		29d. Date signed			
5		30. Name and address of person who		ath (Item 23a) (	(Type, Pri	nt) HOSPIT	AL					
Sta		31. Date filed (WG), 0299 2011		's Synature	_							

KIRKLAND, MARIE

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 25283 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> Month **Physician** August 5, 10:50A <sup>M</sup> Konkus Ronald Leland /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore Owings Mills 305 Wyndham Circle, Unit K 8. Date of Birth (Month, Day, Year) March 9,1947 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdav) **Funeral** 1 X M 2 □ F Months Days Hours 64 Pennsylvania **Director** 170-40-2127 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Director Maryland Baltimore Owings Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21117 305 Wyndham Circle, Unit K USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐Yes 2X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Project Executive Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amber Joseph Konkus Flynn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any injury or other trau once. 305 Wyndham Circle, Unit K. Owings Mills, MD 21117 Bonita A. Konkus/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/8/11 Atlantic Crematory Glen Burnie, Maryland 21. Signatur Styreral Service License 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. Enter e isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart feiture. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Fina disease or condition resulting in death) Phyxia **Physician** /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No

Physician: The law requires that the death certificate be executed physician and s the burial-trans attending p signed by the a O. ۵. of Vital Records, has e 2 s page director, this

Division or Attending

Hospital

1050AM

show

27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be medified at

21215-0036

Baltimore, Maryland

Ronald Kon

Certification: To 

Medical

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Mpnth, Day, Year) 5 Pending investigation

28b. Time of Injury 28e. Flace of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

1 ☐ Yes 2 ☑ No

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred Suite de by

28f. Location Street and Num er or Rural Route Number.
City or Town, State.

#4, Owings MILLS, MD 21117 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29b. Signature and title of certifier

6 ☐ Could not be

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GTRIMBLE HILLCTLUTHERVICLE, MD 21093 PHILIP MILITELLOMD

Date filed (Month, Day, Year)

27. Manner of Death

1 🗌 Natural

2 Accident

3 Suicide 4 Homicide

29a, Certifier

32. Registrar's Signature

Registrar

AUG 0 9 2011

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Knight Physician/ Month Thelma 12:154 2011 JULY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Seasons Hospice g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕇 F Days N. Carolina 82 Yrs 0272377929 245-44-1664 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 XYes 2 No N/A Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 1416 Ward St. 21230 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force þ 1 X Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: Black If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Harbor Hospital 12th Grade Dietician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rivanna M. Knight George W. Foster 19a. Informant's Name/Relationship (Type, Print) (Children 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karl, Cassandra, Glenn Key 1416 Ward Street, Baltimore, MD 21230 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Cedar Hill Cem. 08/05/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Forephades of Brown Jr. Funeral Home PA 21. Signature of Funeral Service Licensee Doano 2140 N. Fulton Ave., Baltimore, MD 21217 23 Part 1. Ent f the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line. Onset and Death Immediate Cause (Final -Physician/ ovarian cancer Hetastatic disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Year Pregnant at time of death g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital 4 Nursing Home 5 Residence 6 Dotter (Specify) - mh - spice 1 Yes Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

within 24 hours after death.

To the Funeral Director. After it

Registrar

only one)

ms Zojapahni M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5. Rajapak FR /M.D

DHMH 17 Rev 7/2009

1835 5min

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DO057465

5- 703

7/26/11

Baltimon Mozizog

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center **Baltimore**  Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours 216-34-8533 1 № M 2 🗆 F 2 Freb Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 'natural", or Items 23a or 28a-f show 1 √es 2 No at the Medical Examiner must be notified Directo timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 708 21206 Funeral Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 2 No 1 Never Married 2 Married 1 □ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: 2 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Is marked other than Baker Package 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DIMON ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any Injury or other tra larry A. 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Dourial 2 Cremation 3 Removal from State Aug 11,209 4 Donation 5 Other (Specify) WETERY 21. Signature of Funeral Service Licensee 22. Name and Address of acility tredtitinfan, Approximate Interval Between 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause caused the death. Do not softer the mode of dying, such as cardiac or respiratory each line Immediate Cause (Final la i ue to (or as a consequence of) Physician disease or condition /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical certificate be use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy Day Month in the past 12 months? eral Director: After this certificate has been signed by the atten filled in by the funeral director, page 2 should be detached for a 5 Other (specify) Pregnant at time of death 2 🗌 No 9 Unknown P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be perform 2 No No 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA ည 1 Yes Inpatient Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of 28b. Time of Medical Certification: (Month, Day Year) 1 Natural Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office 4 Homicide building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doctor

29c. License number

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25286 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2011 ear Physician/ Day August 5, Donna Lee Lacko 5:37 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Days Sept. 13 1 M 2 X F Months 164-46-2358 1954 Maryland Director 56 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2XXVo Maryland Harford Fallston 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1700 Oakmont Road 21047 United States 'natural", or items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force þ 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than " Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Support Services Manager Banking is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Roland Davis Patricia Ann Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Martin F. Lacko / Husband 1700 Oakmont Road Falston, Maryland 21047 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 10, 1 Burial 2X Cremation 3 Removal from State Evanse Funeral of Chapel 4 Donation 5 Other (Specify) Bel Air 2011 Forest Hill, Maryland 21. Signature Funeral Service Licensee Evans Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. sician/ CP 3 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or in that initiated events and burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth Z L retarded
Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Hospice 1 ☐ Yes 2 XNo Other: ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1/ Natural s after death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ly one) 29b. Signature and title of certifier 001178 Name and address of person who completed cause of death (Item 23a) (Type, Print) 4105 B halls

DHMH 17 Rev 7/2009

State Registrar

Registrar

Division of Vital Records, P.O. Box 68760

Maryland

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8813

32. Registra's Sign

Shah

D 69 540

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Suite 204 Paykville MD 21234

06 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend items 20a-c per fh 9918 8-12-11 vt
State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death Reg. No. 2. Date of Death 3. Time of Death A Month 1. Decedent's Name (First, Middle, Last) Ye ar **Physician** 10:30 AM 2011 ugusl /Medical 4b. City, Town, or Location of Death 4c. County of Death acility Name (If not institution, give street and number) Examiner NA MORR Ree RIWA 9. Birthplace (State or Foreign Country) MARY 14 w 11 If Under 24 Hrs. Security Number (In yrs. last birthday, Year **Funeral** Months Hours 63 1 □ M 2 🗗 F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be rediffed at 1 Yes 2 No TARIHAM 10RQ Director 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 @ Yes 2 No If Yes, Give 1 001 1004 Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) stitute (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) anould be final and Mental Hy Be ပ 19a. Informant's Name/Relationship (Type, Print) Aton of Health 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If it any Injury or or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State EastPoint, Md. 8-15-2011 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn 22. Name and Address of Facility Charnacki Faneral Homes P.A. W. Dabkows M. Charnacki Faneral Homes P.A. 1005 Pandalk Aup. Baltimorg Nd. 21224 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LIPOSARCOMA 4 Months PLEOMORPHIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is consistent to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transi and Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria P.O. Box 68760. death certificate be Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) Tyes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown this certificate has been a al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 ☐ Yes 1 Yes Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 2 **N**O 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To Funeral Director After the stely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐No death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined e Hospital or A 4 | Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUGUST 08 2011 1650 ORLEANS ST , CRB I GEG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK MEYER MD FUD MD 21231 BALTIMORE, HRISTIAN Date filed (Month, Day, Year)

Registra.

State of Maryland / Department of Health and Mental Hygiers For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death <sup>Day</sup> 2011 Physician/ Month Beatrice LASKOWITZ 10:05 P M August 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Year) 1 □ M 2 👿 F Hours 218-01-1993 93 **Director** 1917 Maryland Usual Residence of Deceden 28a-f show 10a. State with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number ŏ 10f. Zin Code 10g. Citizen of What Country? Funeral items 23a United States 20901 9421 Weaver Street Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify Specify: white Completed 3 X Widowed 4 Divorced al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Woodward & Lothrop/ (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home <u>Sales Associate/Homemaker</u> Be 18. Mother's Name (First, Middle, Maiden Surname)
Bertha Block 17. Father's Name (First, Middle, Last) and Mental h ပ Lewis Cohn 19a. Informant's Name/Relationship (Type, Print) Adrienne Kochanski, Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 13709 Hobart Drive, Silver Spring, MD 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Shaare Zion Cemetery | 08/09/11 Rosedale, MD 4 Donation 5 Other (Specify) 21. Slandure of Furrelal Service Linux Toroninskyshlebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that eached the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph, sician/ Acute Myocardial Infarction disease or condition less Than Medical resulting in death) Due to (or as a consequence of) 1 week Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury that initiated events physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? for Month Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Dementia, Coronary Artery Disease, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? Hyperlipidemia 24a. Was an autopsy performed? Yes 2 X No 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: ပ 1 X Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 💢 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No ours after death. Ieral Director: A filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI August 7, 2011 D 0068681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charu Maheshwary, M.D., 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25290 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Lawrence Jr. Chester Monroe 9:30a 2011 08 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 735 East 21st Street 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 0 09 49 1x M 2 □ F Months Days Hours 219-52-8950 Yrs MD Director 61 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits Ħ 10c. City, Town or Location Director notified Baltimore MD NA 1 X Yes 2 □ No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be items 23a Funeral U.S.A. 735 East 21st Street 21218 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. or þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 √ No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Assembly Line Worker Black and Decker 9th grade na 27 is marked other traumatic event, f Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ည Catherine Gaither Chester Lawrence Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 735 East 21st Street, Baltimore, Md 21218 1 and 2 s of Health item 27 Vernon Lawrence Sr.-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/5/2011 4 Denation On-Site Baltimore, Md 21. Signatur of uneral Service Licensee 22. Name and Address of Facility March F/H West Wabash Baltimore, Approximate Interval Between Onset and Death 23a. Part 1 nter the disea e, or complications that caused the death. Do not enter the mode of dying, such is cardiac or respir tory arrest, Immediate Cause (Final disease or condition Priysician/ Medical resulting in death) ue to (or as a conse meno Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months?

1 Yes 2 No Year Month Day led by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of det ğ page 2 should be law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Records, Completed 245. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to predica ā Be 26. Place of Death (Check only one) examiner? Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 K Residence 6 Other (Specify) ot 27. Many of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Number Practicines 12 the best of my heavier 22 at the cause at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Morth, Day, Year) no completed se of de

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Regina R. Littleton - Filce • 55a 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex . Age (In yrs. last birthday) Country) NJ **Funeral** Days Jan 29 1 🗆 M 2 🗀 🔀 83 1928 146-22-7629 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 333 Torner Road 21221 USA 72 hours after death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 **K** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White and Mental Hygiene. 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home 12th Be and 2 should be filed a Health and Mental Hvc 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Samuel Filce unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen McCollam /daughter 333 Torner Road Balto. MD 21221 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 8/8/11 Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed -tran pue Due to (or as a consequence of): physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the attending properties for use as SS IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death ed by the a signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate the completed filled in by the funeral director, page the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Checl Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of certifier 29b. Signature and title 29d. Date signed (Month, Day, Year) D0071287 . Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 4105, Baltinere, mo 21204

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State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month  $20^{19}$ Chia-Chih Liu August 6:00 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral**  Birthplace (State or Foreign Country) 8. Date of Birth Hours Min Months Director 337-48-7822 September 19 1922 China 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director Maryland | Montgomery 1 🗌 Yes 2 💢 No North Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10905 Outpost Drive 20878 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Asian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Diplomat Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shao-Yuan Liu Unknown Wang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Li-Yun Liu /Wife 10905 Outpost Drive, North Potomac, Maryland 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State August 2011 15, 4 Donation 5 Other (Specify) Parklawn Memorial Park Rockville, Maryland Signature of Fun I Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 Theyeletto Bryn is M01305 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ cardina Medical resulting in death) Due to (or as a consequence of): **Examiner** respira Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed severe cardion attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month cate has been signed by the a page 2 should be detached a 1 ☐ Yes 2 ☐ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Were autopsy findings available 24a. Was an autops, performed a 2 No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No မ Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 PInpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at after death. Director: After 28d. Describe how injury occurred 1 Natural work?
1 \( \sum \) Yes 2 \( \sum \) No 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 1 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D00 644 78 August 2, 2011 meliau 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Fischatsion Mchari, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CAROLINE CAROLYN LAWRENCE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BEL ALX

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

DEC. 30, 1918 MARYLAND LORIEN BEL AIR ASSISTED LIVING BEL AIR 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 💢 F 215-01-6743 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No N/A MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 3714 FOSTER AVENUE 21224 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 1 □Yes 2 X No Specify. Specify: 3X Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NEHMSMAN ELIZABETH VOGEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANDREW LAWRENCE/ SON BEACH COURT, OCEAN PINES, MARYLAND 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART OF JESUS 8/8/1|BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Licensee 22 Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME
700 S. CONKLING STREET, BALTO., MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Due to (or as a consequence of): Sequentially list conditions, ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonnequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ATRIAL FIBRILLATION, HYPERTENSION, 1 Yes 2 No 3 Probably 4 Unknown PERIPHERAL VASCULAR DISEASE SEVERE 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No HYPOTHYRO/D 1 □ Yes 1 ☐Yes 2 ☐No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ASSISTED

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Physician /Medical Examiner

permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic evones.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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be filed within 72 hours after natal Hygiene.

Baltimore, Maryland 21215-0036

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Funeral

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Director: After this certificate has been signed by the attending physi	in by the funeral director, page 2 should be detached for use as the b	
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P.O. Box 68760 Records, The law Attending Physician:

Physician/Medical Examiner 2 Completed Be Certification: To

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 ☐ Yes 2 X No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only

3 Suicide

29a. Certifier

Vital ō To the Hospital or Al within 24 hours after or To the Funeral Direc

> State Registrar

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 245344 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) GZZ S.UNION AVE, HAVREDEGRACE, MDZ1078 DHANJAN 32/Registrar's Sig

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day, Year)

To the Hospital or within 24 hours aff To the Funeral Di completely filled in

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Certification:

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one) Medi

1 V Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 V Homicide 29a. Certifier 1

29b. Signature and title of certifie

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OCME 2006

Zabiullah Ali, M.D. State 31. Date filed (Month, Day, Year) Registrar

AUG 0 9 201

30. Name and address of person who completed cause of death (Item 23a)

2 No

5 Pending

6 Could not be

Investigation

(Specify) Townhouse / Rowhouse

Hospital: 1 Inpatient 2

28a. Date of Injury (Month, Day, Year) Aug 3, 2011

ORIGINAL

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ER/Outpatient 3

0000 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc

28b. Time of Injury

Other<sub>4</sub>

28c. Injury at Work?

29c. License number

OCME

1 Yes 2 V No

Nursing Home 5 Residence 6 🗸 Other: Scene

or Town, State) 4708 Moravia Road , Baltimore, MD

28f. Location (Street and Number or Rural Route Number, City

August 4, 2011

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

Subject assaulted

**OCME** 

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Anita Louise Marshall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel 9. Birthplace (State or Foreign Country) Maryland **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, March 2 7. Age (In vrs. last birthday Day 1 □ M 2 💢 F 212-36-9259 Director 70 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 511 Jumpers Hole Road 21146 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 X Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pet Care Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mildred M. Hobson Edward F. Reillv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne J. Marshall, 511 Jumpers Hole Road Severna Park, Maryland 21146 Husband 20a. Method of Disposition
1 ☐ Burial 2 XCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory Inc. 08/12/11 2. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 Signature of Funeral Service License Thomas Gregor Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complication Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequer the attending physician and ched for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has k funeral director, page 2 autopsy performe 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident filled in by the 6 🗌 Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier 📉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 2011 O ss of person who completed cause of death (Item 23a) (Type, Print) 01

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25296 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lillian Mones 201<sup>Year</sup> 7:45 pM August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c County of Death Montgomery 9533 Bexhill Drive Kensington Social Security Numbe **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X X Days Hours Min. 90 204-20-4197 7 /23/192 **Director** Yrs PA Usual Residence of Decedent 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State 10b. County c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Kensington 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral USA 20895 9533 E. Bexhill Drive Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3₺ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Fine Art Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 is marked o ျ Isaac Ravinowitz Sophia Richmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Mones, son 9533 E. Bexhill Dr. Kensington, MD 20895 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If ite any injury or of 1 Burial 2XXCremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 8/6/2011 Beltsville, MD Signature of Funeral Service Lic 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Months Physician/ Cerebrovascular Accident disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner High Blood Pressure 5 years Sequentially list conditions, if any, having to immediate cause. Enter Underlying Exami Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) 1 Live Birth 2 Fetal deal
4 Pregnant at time of death
9 Unknown Ectopic pregnancy in the past 12 months? Day signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Dementia Division of Vital Records, Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons 2 🔼 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: completed filled in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA hours after death. meral Director: After this Nursing Home 5XXResidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0023137 8/5/2011 on m. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nealon, Kevin MD; 5530 Wisconsin Ave. Chevy Chase, MD 20815

Registrar

DHMH 17 Rev 7/2009

State

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			For State	State of	Maryla		artment of F		nd Ment	al Hygi	ene	1	25207
			Registrar  1. Decedent's Name (First, Middle, La	ect)		Cer	tificate of <u>L</u>	Jeath	To D	Re te of Death	g. No. U		25297
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	Funeral Director		214-20-32/9	Sex I□M2 <b>X</b> F	. Age (In yrs. <b>89</b>	last birthday) Yrs.	If Under 1 Year Months Days			te of Birth onth, Day, Y	(ear) 1922 F	Count	lace (State or Foreign ry) sylvania
	nd how at	=	Usual Residence of Decedent  10a. State 10b. County		10c, C	ity, Town or Loc	cation		_			1	Od. Inside City Limits
	larylar 3a-f s ified	Director	Maryland Balti	more		Over.							1 ☐ Yes 2 🛣 No
	the N or 28		10e. Street and Number	MOLC		OVCI.	10f. Zip Code			10	g. Citizen of Wh	at Coun	try?
	s 23a	Funeral	4013 Chesley A	venue			2120	)6			U.S.A.	,	
Maryland 21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fur	11, Marital Status  1 ☐ Never Married 2 ☐ Married  3 🏋 Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? <b>XX</b> No	Н	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 XNo	n, Mexican, F	n? (Specify Ye: Puerto Rican,	or No- etc.)	14. Race - Black, Specify:	White, e	tc.
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			George March/So				g Address (Street a			Number, C Ltimo:			
re,	1 and of Heali item 2		20a. Method of Disposition			Place of Dispos	sition (Name of		Date		0c. Location - C		
E	Page nent c ant: If		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec.		late		patory or other plac Park Cem	´ ;	8/08/20	011	Baltimo	re	MD
Baltimore,	permit. Page 1: Department of I Important: If it any injury or of		21. Signature of Funeral Service Licen	\$ @			Name and Addres	s of Facility		eral	Home, In	ıc.	21206
			23a. Part 1. Enter the disease, or on shock, or heart failure. List only	plications that cau	used the dea	th. Do not ente	r the mode of dying	g, such as car	rdiac or respir	atory arrest	,	ш_	Approximate
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Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outco 1  Live Bir 4  Pregna 9  Unknow	th 2 🗀 Fet nt at time of	al death 3 🗌	Ectopic pregnance Other (specify)	у			23d. Date Month		ry Day Year
P.O.	hat the de ed by the detached	y Ph	Part II. Other significant conditions of	ontributing to dea	th but not res	sulting in the ur	nderlying cause giv	en in Part I.	23	e. Did toba	cco use contribu	ute to the	e cause of death2
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	To the Hospital or within 24 hours afte To the Funeral Dir completed filled in	Medical	29a. Certifier (Check (Check only one) 3 Certifying Nur	iner: On the basis	of examinatio	n and/or investi	ocured at the time, gation, in my opinion	<ol> <li>death occur</li> </ol>	rred at the time	date and	place and due to	the caus	se(s) and manner stated
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			30. Name and address of person who	completed cause of	of death (Item	670/	MERIH (	CHEVER	-5 574	10cm	BALTIM	CK2	ZUVI MDZIZOG
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DHMH 17 Rev 7/2009

Please Type of Print in Black Indelible In/20 Finsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25298 Reg. NoZ U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month August Steven 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOPKINS HUSPITAL The Johns Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Sept. 1, 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 220-92-4795 1964 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f shov the Medical Examinatings to notified at Director 1 ☐Yes 2 ☐ No Md. Harford Edgewood 10e. Street and Number 1727 A Fountain Rock Way 10g. Citizen of What Country? 10f. Zip Code 1727 Fountain Rock Way 21040 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. White Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Receiver Pharmacutical Company permit, Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ronald James Marotta Christine Adelle Fiorillo 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Fallston 21047 19a. Informant's Name/Relationship (Type. Print) <u>Fallston</u> Chr<u>istine</u> R. Marotta-Mother <u> 1124</u> Sturbridge Road <del>Edgewoo</del>d, Md. <del>21040</del> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) c Crematory 3/8/ 22. Name and Address of Facility 8/7/2011 Glen Burnie, Md. 21. Signature of Funeral Service Licensee Schimunek Funeral Home 610 West MacPhail Road Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician with multifical brain lesions nemor/huge /Medical Due to (or as a consequence of): Examiner lumun Immunode Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the bunal-trans Due to (or as a consequence of): Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 5017UVES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 **Y**No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 (BAIfUUTA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltmore MD, 21267 184 HOY TM, MUNA 31. Date filed (Month, Day, Year) AUG 0 9 2011 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2011 8:20 Рм August Anthony Ν. Mikalis 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Frederick Sunrise Assisted Living Frederick Social Security Number 9. Birthplace (State or Foreign Country)
Greece If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Days Min Month, Day, Yea February 4, 1 🗶 M 2 🗆 F Months Hours 259-48-4227 Yrs. 1930 81 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Rockville Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Box 157, 5576A Norbeck Road 20853 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🙀 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Department of Health and life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Human Resources Officer of Civil Rights 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anastasia Elafopoulou Nicholas Frangiskos Spanomichalakis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 157, 5576A Norbeck Road, Rockville, Maryland 20853 Odysseus Mikalis /Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 9. 1 X Burial 2 Cremation 3 Removal from State Silver Spring, Maryland Gate Of Heaven Cemetery 2011 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Atherosclerosis Coronary Artery Disease disease or condition resulting in death) Due to (or as a consequence of) Parkinson's Disease Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown

Physician/ Medical **Examiner** 

executed

that the death certificate be

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires

Physician/

Medical

Examiner

**Funeral** 

**Director** 

28a-f show

items 23a or 28a-f sho her must be notified at

er than "natural", or iter the Medical Examiner

. Hygiene. other than "

and Mental Hygier 7 is marked other t

permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau

other traumatic event,

death v

Baltimore, Maryland 21215-0036

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Funeral

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Completed

Be

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Exami sician and burial-trans physician the burial Physician/Medical attending p by Completed Be မ within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i Certificate:

24a. Was an 24b. Were autopsy findings available

						performed?  1  Yes 2  No	death? 1 Yes 2 No
25. Was case referred to medical examiner?					26. Place of Death (Chec	ck only one)	A1 - 3
1 Yes 2 X No	Hos	spital: 1  Inpatient 2	ER/Outpatient	3 🗌 1	DOA Other: 4 \( \sum \) Nursing H	lome 5 ☐ Residence 6 🗓	Assisted Other (Specify)Living
27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident Investigs	ation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	М	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury oca	curred
	Could not be determined 28e. I	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street	, facto	ory, office	28f. Location (Street and Nu City or Town, State)	umber or Rural Route Number,
20a Cartifiar 1 V Cartifuing I	hunini	on. To the heat of my knowl	ladae deeth ees	unad e	at the time date and place a		and an activities

29a. Certifier 1 X Certifying Physician: To the best of my knowledge, de	ath occured at the time, date and place, and due to t	he cause(s) and manner as stated.
(Check 2 Medical Examiner: On the basis of examination and/or in	nvestigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s) and manner state
only one) 3 Certifying Nurse Practioner: To the best of my knowled	lge, death occurred at the time, date and place, and due	e to the cause(s) and manner as stated.
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
I Company	D47951	August 4, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sibte A. Kazmi, MD 814 Tollhouse Avenue, Frederick, Maryland 21701

State Registrar

Medical

31. Date filed (Month, Day, Year, 32. Registrar's Signature AUG 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 12:50 EUGENE MILLER JULY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMERE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day Year) Oct 15, 1951 Days Hours Min 1 X M 2 🗆 F Months SC 59 216-58-3344 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director X 1 ☐ Yes 2 ☐ No **Baltimore Baltimore City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21229 3 North Hilton Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Black If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **UMMC** Electrician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carrie B. Ford Talmadge Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 North Hilton Street Baltimore, MD 21229 Carrie E. Ford Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Aug 05, 2011 Baltimore, Maryland Arbutus Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 21. Signature III eral Service Licen Party, Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ NECROTIZING FASCIITIS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy ò in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ျ Inpatient 2 🗆 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X-Natural work? 5 Pending 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗖 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c License number

Registrar
DHMH 17 Rev 7/2009

State

25582

UNIVERSITY OF MARYLLAND MEDICAL CENTER 22 SOUTH GREENE ST, BALTIMORE MD 21201

JULY 29, 2011

M.D.

32. Registrar's Signature

park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SVFAREDINI,

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Dorothy D. Martin Month Medical Ju 101 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL BURNIE GLEN BALTIMORE WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth 2135e2810685 **Funeral**  Birthplace (State or Foreign Country) 1 🗆 M 2 🗶 F Days Min (Mo Oct 19, 1925 85 **Director** 213-25-0685 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Glen Burnie MD **Anne Arundel** 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21061 8217 Oakwood Road permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 11. Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, WI à 1 Never Married 2 X Married Maryland 21215-0036 Black 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Important: If item 27 is marked other than any injury or other traumatic event, the Moconce. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alverta Bessick Joseph Bessick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8217 Oakwood Road Glen Burnie, MD 21061 Phillip N. Martin Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Crownsville Veterans Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Crownsville, Md. Aug 05, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Etcensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eachdine. Approximate nterval Retween Immediate Cause (Final Onset and Death Physician/ ARDIAC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Section tight list over little as Examiner if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ned by the atter detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending Accident 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MSULVER. Monicity DMONG 31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 7/2009

MARTIN

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RobertaA 11:57 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Masyland Medical Center Baltimore, Mariland Baltimore City 8. Date of Birth (Month, Day, Year) 10/20/1942 9. Birthplace (State or Foreign **Funeral** Country)
West Virginia 1 □ M 2 🛛 F Hours Min Director 214-46-0331 68 Usual Residence of Decedent 28a-f show 10c. City, Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Co. Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** 21108 339 Regina Court United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify 3 🕅 Widowed 4 🗆 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the 11 yrs. Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Gertrude Josephine Robert Vinsand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Sunshine Lane Middletown, DE Mrs. Kristina De Los Reyes/Daughter Baltimore, If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 8/12/2011 Glen Burnie, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services, PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of). disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate Examine Cause (Disease or linjury Systemic immunosuppresion that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by adaveric renal transplant 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No Other: မ 1 Yes 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier

State Registrar

Box 68760

P.O.

Records,

Division of Vital

of death (Item 23a) (Type, Print)

Green Street, Bultimore, MD 21201

30. Name and address of person who completed cause

31. AUG-01912011

			Pleas	e Type or Pri						_	
			For State Registrar		-	partment of I ertificate of I		Mental Ḥy	/gienę Reg. N		25303
	Physicia Medic		Decedent's Name (First, Middle, L. William	B	•	Newby		2. Date of D Month AUGUS	Da	year Year	3. Time of Death 10:36 PM
arres	Examin	er	4a. Facility Name (if not institution, gi SiNAL HOSPITAL	,	MORE		or Location of Death		40	c. County of Deat	h
	Funeral Director		5. Social Security Number 6. 219-05-4583		e (In yrs. last birthda 91 Yrs	y) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bi (Month, D	ay, Year)	Co	thplace (State or Foreign untry)
	ind show at	៦	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
	Maryla 28a-f otified	Funeral Director	MD NA		Balt	imore					1 🌠 Yes 2 □ No
	vith the 23a or st be n	ral D	10e. Street and Number 2095 Rockrose	Δνο		10f. Zip Code	.211		10g. C	itizen of What Co	
	death v items her mu		11. Marital Status	12. Was Decedent I	Ever in U.S. 1	3. Was Decedent of H If Yes, specify Cub		pecify Yes or No	)- 	14. Race - Ame	rican Indian,
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	ted by	1 Never Married 2 Married 3 Divorced	1 X Yes 2 If Yes, Give Year or Dates.	No	1 ☐ Yes 2x No	Specify:	, , , , , ,		Specify: B1	
215-(	י 72 ho <b>an "nai</b> <b>Medic</b>	Completed	15. Decedent's (Specify only highest (Elementary/Seconday (0-12)		(Gi	cedent's Usual Occup re kind of work done DO NOT use retired	during most of wor	king	16b. h	Kind of Business	Industry
212	d withir ygiene <b>her th</b> nt, the	Be Co	12th grade	na	'	ber Chec					ion Co.
land	be filer ental H ked ot ic ever	To B	17. Father's Name (First, Middle, Last Eddie Newby	)			18. Mother's Nar Hazel		e, Maiden	Surname)	
lary	should and M is mar aumat	- 25	19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Address (Street			er, City o	r Town, State, Zij	o Code)
ē,	and 2 Health tem 27		Albert Johnson 20a. Method of Disposition	-Son		Cumberl	and Str	eet, F		imore.	Md 21217 Town State
mo	Page 1 nent of ant: If ii ury or o		1 <b>X</b> Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State	cemetery, c	rematory or other pla	i	/2011			ills, Md
Baltimore, Maryland	Departr Mports any inju	1	21. Signature of Funeral Service Lice	nsee A A	+	22. Name and Addre	ess of Facility H West			2000 Feb. 0-	
		+	23a. Part 1. Enter the disease, or co		the death. Do not e	4300 Wab	ash ave			re, Md	21215 Approximate
والمامو	Physician/		shock, or heart failure. List only Immediate Cause (Final disease or condition	ACUT	F LUNG	INJURY					Interval Between Onset and Death
nd.	Medical Examiner		resulting in death)	,	RATION	PNEUMO	NITIS				8 days
	π ±	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						
	executed ian and irial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	C	a consequence of):	EMENTIA					
09	ate be e hysicial he buri	dical	•	d							
Box 68760	the Hospital or Attending Physician: The law requires that the death certificate be hin? A hours after death certificate be the Funeral Director. After this certificate has been signed by the attending physic inpleted filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal death	B ☐ Ectopic pregnan Do ☐ Other (specify)	ю			23d. Date of de Month	livery Day Year
P.O.	requires that the de been signed by the s should be detached	by	Part II. Other significant conditions	contributing to death b	ut not resulting in th	e underlying cause g	iven in Part I.			/	the cause of death?
ords	require been si should	leted						1 L			robably 4 Unknown
Reco	sician: The law is certificate has k	Completed						aut	opsy formed	prior to	completion of cause of
/ital	/sician s certifi director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	ent 2 🗆 ER/Outpa	Lott	Place of Death (Che		ridence	6 ☐ Other (Spec	siful
n of \	iding Phys th. After this funeral dir		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of inju (Month, Da	ry 28b. Time	of 28c. Inju	ry at k?	28d. Describe			
Division of Vital Records,	e Hospital or Attendi 124 hours after death. e Funeral Director: A pleted filled in by the fu	Certificate:	2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of Inju	M 1 ☐ Yes 2 ☐ No  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28		28f. Location City or To			ral Route Number,	
Ω	Hospital 24 hours Funeral sted filled	Medical	(Check 2 Medical Exa		xamination and/or inv	estigation, in my opin	ion, death occurred	at the time, date	and plac	e, and due to the	cause(s) and manner stated
	To the within 2 To the comple	Ž	only one) 3 ☐ Certifying No 29b. Signature and title of certifier	erse Practioner: To the	best of my knowledg	e, death occurred at the 29c. Licens		ace, and due to		(s) and manner as ate signed (Mont	
			▶ Vc	1			5 - 000		A	ug, 5,	2011
١			30. Name and address of person who BRIJEN UOSH		eath (Item 23a) (Type		VAI HO	SPITA	10	F BAL	TIMORE
	Stat		31. Date filed (Month, Day, Year)  AUG 0 9 2011		ar's Signature	1					
	Registra	ar .	NUU U 3 ZUII	Lenery 1	s. grave						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25304 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 40,AM Medical ion, give street and number) **Examiner** HOWL If Under 2 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 376-66-6479 1**X** M 2 □ F Months Days Min 52 Yrs **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Baltimore Woodlawn MD 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2215 Lukewood Dr. 21207 USA ould be filed within 72 hours after death v od Mental Hygiene. marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner African 1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 Divorced 4 Divorced Amer. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Verizon Elementary/Seconday (0-12) Tech. Engineer permit. Page 1 and 2 should be filed wit.
Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Betty Reed Joseph C. Newell, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Nevell/Wife 2215 Lukewood Dr., Woodlawn, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 8/13/11 Balt.,MD Bayview Crematory 4 Donation 5 Other (Specify, 22. Name and Address of FacilityHari P. 21. Signature of Ineral Serice Licens 22. Name and Address of FacilityHari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes ဂ္ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 27. Manuer of Death Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No ė 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pendina Certificat Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number DS3850

Registrar
DHMH 17 Rev 7/2009

State

erson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
amend #19b Per FH G918 8/12/2011 JH

Certificate of Death

Reg. No. 20 | | For State Registrar 25305 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2011 Physician/ 601 PM 0 Nickel Anna Medical Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 4c. County of Death **Examiner** N/A Part Hwo-Franklin weeds Genesis City 8. Date of Birth (Month, Day, Year) February 29, 1911 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min. Country) 218.26.4441 95 Yrs. Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Baltimore Sparrows Point MD 1 Yes XX No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 2825 21219 Lodge Farm Road, Apt, 283 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Felix Kotowski ဂ္ Wadyslawa Zablinski 19b**1.52.5** Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6525 National Road, Baltimore MD 21237 19a. Informant's Name/Relationship (Type, Print) CAtherine Jarkiewicz /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town, State St. Stanislaus Cemetery 1 Burial 2 Cremation 3 Removal from State 8/6/11 Dundalk MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda <sup>22</sup> Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heurt Fuilvre Ph\_sician/ 1 week disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertersing Amerositentic Curclio resource Discusse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 NO 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No Other: ၉ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 1103 H 2011 tui Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Fort haltimore 901 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 2011 12:18 PM Nixon Gary Lloyd Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOWSON SAINT JOSEPH MEDICAL CENTER 1 Year If Under 24 Hrs.
Days Hours Min. 8. Date of Birth (Month, Day, Jan 25, If Under 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** 1 🗶 M 2 🗆 F Months Oklahoma โ941 **Director** 443-38-5974 70 Usual Residence of Decedent 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County Completed by Funeral Director 10a. State the Maryland other traumatic event, the Medical Examiner must be notified at 1 🗌 Yes 2 ី No <u>Baltimore</u> Phoenix Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2408 Carroll Mill Road or items filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Motorcycle Racing Professional Motorcycle Racer 12 n/a Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) item 27 is marked o ည Page 1 and 2 should be F1oy **Arlene** Coombs Delmar Nixon Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2408 Carroll Mill Road, Phoenix, Maryland Mary Nixon/Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ō <del>I</del> cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State ö permit. Page Department of Important: If any injury or Aug 11, 2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) lantic Crematory 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc Clary Padonia Road, Timonium, Maryland 23a. Part 1. Exer the disease, or complications that cause shock, or heart failure. List only one cause on each lin d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate € ause (Fi Phytician/ CORONARY ARTERY DISEASE disease or condition resulting in Teath) Medical Due to (or as a consequence of **Examiner** VENTRICULAR ARRHYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) CARDIOMYOPATHY use as the burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death Yes 2 No director, page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 X No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital Other: မ 2 🗌 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural
Accident work' 5 Pending 1 Yes 2 No M death Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title D0068861 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE FARHAN MAJEED M.D. TOWSON, MD 21204 State Registrar

DHMH 17 Rev 7/2009

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygicane  1- For State Registrar Reg. No.	5307
Physician /Medical	1. Decedent's Name (First, Middle, Last)  Pauline Nina Naill  2. Date of Death Month Day Year ACUST & 2011	3. Time of Death  2 1 3 4 A M
Examiner Funeral Director	220-38-9346   10 M 250   69 Yrs.   Dec. 14, 1941   Mary 1	ice (State or Foreign y) and
h tha Maryland r 28s-1 show incillise at Irector	Total State Total	d. Inside City Limits 1  Yes 2 □ No
Baltimore, Maryland 21215-0036  parmit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiana. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Exeminar must be notified at once.  To Be Completed by Funeral Director	4335 Newport Avenue  21211  USA  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Sive 1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 1 Yes 2 No Specify: White	tc.
Baltimore, Maryland 21215-0036 samit. Pages I and 2 should be filed within 72 hours att Department of Haaith and Mental hygiana. mportant: if item 27 is marked other than "natural", or nny injury or other traumatic event. the Medical Exempance. To Be Completed by F	16a. Decedent's Usual Occupation (Specify only highest grade completed)  Elementary/Secondary (0-12) Unknown  17. Father's Name (First, Middle, Last)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Clamp Production  18. Mother's Name (First, Middle, Maiden Sumame)	
Aaryland 2 should be filt and Mental Hy is marked oth reumatic event	17. Father's Name (First, Middle, Last)	
imore, N Pages 1 and mant of Haath ant: If item 27 iury or other it	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Locust Grove Cemetery  8/11/2011  Mt. Airey, Mary	vn, State
Balt parmit Dapart import eny Inj once.	23a. Part : Enter the disease, of combinations that cause the death. Do not enter the mode of dying, such as our factors	Approximate Interval Between Onset and Death
cartificate be executed indig physician and ise as the burial-transit authority.	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	ldy
cords, P.O. Box 68760,  wrequires that the death cartificate be ex been signed by the attending physician should be detached for use as the burial leted by Physician/Medical E.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  Mo 9  Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify) 9  Unknown	ry Day Year
cords, vequiras the bean signal should be districted by	Part II, Other significant conditions contributing to death but not resulting in the discountrying cause given in rank.	osy findings availab
Division of Vital Records, To the Hospital or Attending Physician: Tha law requires t within 24 hours after death. To the Funeral Director: After this cartificate has been signs completely filled in by the funeral director, page 2 should be a Medical Certification; To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No State of Death   Check only one    1 No State   No Stat	)
DIV To the Hospital or within 24 hours attain To the Funeral Dire complately filled in b Medical Certi	29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  CREAS Signature and file of certifier  29a. Certifier  29a. Certifier  29a. Certifier  29b. Signature and file of certifier  29c. License number  29d. Date signed (Month, I	the cause(s)  Day, Year)
State	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AVITED (HUNICHUM)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ACTIMUZ!
Registrar  DHMH 17 Rev 1/2001	AUG 0 9 2011 Sener D. Jakes	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 25308 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 9:05 August Frank M. Nelson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Potomac Emeritus Assisted Living If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Days February 13, Months Hours Min. 1 💢 M 2 🗆 F 1922 California 89 Director 577-52-2582 Usual Residence of Decedent f show 10b. County 10c. City. Town or Location 10a. State 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No Potomac Maryland | Montgomery 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20854 United States 11215 Seven Locks Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No WWII
If Yes, Give Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify. 3 Widowed 4 X Divorced Completed Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) and Mental Hygiene. Self-Employed Consultant other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Matilda Burkhart Frank E. Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 5211 Claridge Court, Fairfax, Virginia 22032 Gregory F. Nelson/Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place)
Montgomery
Crematorium, Inc. ☐ Burial 2 X Cremation 3 ☐ Removal from State August 7, 2011 Bethesda, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. Horan mai M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Malignant Neoplasm; Bones of Skull and Face Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Diabetes Mellitus Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exami The law requires that the death certificate be executed Alzheimer's Disease Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hypertension attending physi IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 N Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv page performe 1 🗌 Yes 2 🗌 No 1 Yes 2 X No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (SpecifyLiving examiner? Hospital 1 🗌 Yes 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury

Division of Vital Records, P.O. Box 68760 or Attending Physician:

To the nosperse within 24 hours after death.

To the Funeral Director, After the Suneral Director After the Suneral Su funeral the Hospital

work? 1 🗌 Yes 2 🗌 No 5 Pending 1 X Natural Accident Investigation 2 Accident
3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

August 5, 2011

29c. License number 29d. Date signed (Month, Day, Year)

R151747

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15245 Shady Grove Road Suite 130, Rockville, Maryland 20850 CRNP, Nkiru Ezeani,

31. Date filed (Month, Dav. Year)

32. Registrer's Signature

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ July 20 T 2ay 24 4:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 0 Montgomery Shady Grove Adventist Hospital Rockville ف 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, lar.31, 1 Months Days Hours Min Burma 219-61-3731 80 Director Mar. 102/72 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland must be notified at Director MD Montgomery Gaithersburg 1XXYes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20879 Burma 1147 Southern Night Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian the Medical Examiner Black White etc. 9 Completed by 1 Never Married 2 X Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Burmese Asian "natural" 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ War Saing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 1147 Southern Night Ln., Gaithersburg, MD Tin Kyaw Oo / Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2011 Phoenix, AZ 4XXDonation 5 ☐ Other (Specify) Science Care Signature of Funeral Se Name and Address of Facility.

IPP Funeral and Cremation Services Stolu & Johnson Gist Ave., Silver Spring, 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ respira 01 disease or condition resulting in death) Medical Due to (or as a consequence of Examiner pheumonin Sequentially list conditions, Examine it any wast greet introductions cause. Enter Underlying sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death the Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed by brillation Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown ....oro autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available 24a. Was an has autopsy perform page 2 this certificate 1 Yes 2 No Yes 2 M No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: 1 \sum Yes ည 1 

✓ Inpatient 2 

ER/Outpatient 3 

DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Director: After (Month, Day, Year) 1 Natural 5 Pending death. 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 00068080 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive, Rockville, Mayland 20850 Jalli, MD 990/ Madient Sireesha State AUG 0 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Lillian outten 6'.00A August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Randallstown Northwest Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours 1 🗆 M 2 👿 F 216-36-7031 82 **Director** 29 08 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Baltimore 1X Yes 2 ☐ No NA MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? F must be U.S.A. Funeral 21217 23a 832 Chauncey Ave ıral", or items ? I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural" 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. If item 27 is marked other than r other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Private Homes House Keeper 10thgrade Be 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 832 Chauncey Ave, Baltimore, Md 21217 19a. Informant's Name/Relationship (Type, Print) Edna Outten-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ÷ 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department c Important; If any injury or Woodlawn, Md 8/11/2013 Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility arch F H West 4300 Wabash ave, of Funeral Service Licensee Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death End. Strage Dementia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ☐ Live Birth 2 ☐ Fetal death☐ Pregnant at time of death☐ Unknown in the past 12 months? Month Day Year 5 Other (specify) signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Pother specify Terra nospice 1 ☐ Yes 2 ☑ No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number MSRAJAPAMIM.D DOUS7 465 Baltimore MD 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.S. KYAPAKS / M.D. 2835 Sm 17h 5- 203 AV

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 06, Jay Wilbur Parry-Hill Medical August. 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Baltimore Towson Social Security Number 6. Sex 7. Age (In yrs. last birthday, Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 🔀 M 2 🗆 F 03/22/1947 Director Pennsylvania 215-52-9131 64 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature!" any injury or other traumatic events. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1320 1st Road 21220 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Bace - American Indian. Armed Forces' Completed by 1 Never Married 2 Married 1966 1 Yes If Yes, Give 2 No 1 Yes 2 No Specify: Specify: White 3 🗆 Widowed 4 🗆 Divorced 1970 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Electrician/Project Manager U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Wolfrey Parry-Hill Janet Stranahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Youngmi Parry-Hill (Wife) 1320 1st Road, Baltimore, Maryland 21220 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Holly Hill Mem. Gard. 08/08/2011 Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signature of Mineral Service Licensee Old Fastern Avenue, Essex, Maryland 21221 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im ediate Cause (Final Ph sician/ IRRHUSIS di ease or condition esulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death this certificate has been signed by the all director, page 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ENDSTAGE ROWAL DISCASE 1 Yes 2 No 3 Probably 4 Unknown CARDIO MYO PATHY 24b. Were autopsy findings available 24a Was an prior to completion death? performe PULMONARY HYPERTONSON 1 Yes 2 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital Other: 4 Nursing Home 5 Residence ျှ HOSPIL 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner eath Certificate: 28a. Date of injury 28b. Time of Within 24 hours after death.

To the Funeral Director: After in by the funer 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) atural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie address of person who completed cause of death (Item 23a) (Type AUG 0 9 2011 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $20^{1}$ 2:18 August John Milton Price Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Apple Blossoms Asst. Living Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 🙀 M 2 🗆 F Days Hours Min 1/27/1930 Country) MO Director 491-28-6587 Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. County 10c. City, Town or Location Director 1 Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20008 NW #W202 3003 Van Ness St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Yes 2 No 1953 Yes, Give 1 Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 1957 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ermit. Page 1 and 2 should be filed within epartment of Health and Mental Hygiene aportant; if item 27 is marked other the y injury or other traumatic event, the. Amtrak <u>Writer/Manager</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ruth Jean Sutter Clun Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4710 Bethesda Ave #717 Bethesda, MD 20814 Carl E Uhlig, executor 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl
once. cemetery, crematory or other place) 1 ☐ Burial 2 ☒Xremation 3 ☐ Removal from State Chesapeake Crematory 8/5/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Fun, al Sauco 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hodgkin's + Non Hodgkin's Lymphoma Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐xUnknown Colon Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s <u>Hypertension</u> autonsy 1 Yes 2 No Yes 2 No Chronic Kidney Disease 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Louissisted Living ျှ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Director: After 5 Pending injury 1 XNatural Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after To the Funeral Direct City or Town, State) 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner. On the basis of examination and so involving the source of the basis of examination and source of the basis of examination and source of the basis of examination and source of the basis of examination and source of the basis of examination and source of the basis of examination and source of the basis of examination and source of the basis of examination and source of the basis of examination and source of the basis of examination and source of the basis of examination and source of the basis of examination and source of the basis of examination and source of the basis of examination and source of the basis of examination and source of the basis of examination and source of the basis of examination and source of the basis of the 29d. Date signed (Month, Day, Year) 8/4/2011 29b. Signature and title of certifier 29c. License number Kouatchou, m) D63748 Jocelyne

State Registrar 32. Registrar's Signature

MD; 4041 Powder Mill Rd. Calverton, MD 20705

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou,

Date filed (Month, Day, Year)

AUG 0 9 2011

11-05	910	
loan	Marie	Press

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

oan wane i les	1	l- For State Registrar			ate of Deat			2 U I eg. No.	1 2531.
Physicia ledical Examir	-	Decedent's Name (First, Middle,Last     Joan Marie Pre					2. Date of Dea Month August 6,	Day Year	3. Time of Death 1853 hrs
W. C. S. Con		4a. Facility Name (if not institution, give			4b. City, 1	Town, or Location of		4c. County of Dea	th
		4717 Jasmine Drive			Rock		er 24Hrs. 8. Date of Bi	Montgomery rth(MM/DD/YYYY) 9. B	irthplace (State or
Funeral Director		5. Social Security Number  216-72-1527  Usual Residence of Decedent	M 2XF	yrs. last bir 48	Month		14:-	Fore	
any	-	10a. State 10b. County	100	: City, Town	or Location				10d. Inside City Limits
Maryland 28a-f show 1 at once,	ō		gomery			otomac			1 Yes 2 XNo
the Mary	Director	10e. Street and Number  10209 Bentcross	Drive		10f. Zip	20854		log. Citizen of What Co <b>United</b>	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 X				gin? ( Specify Yes or No , Puerto Rican, etc.)	White, etc.	erican Indian, Black,
urs after c tural", o	<u>a</u>	3 Widowed 4 Divorced  15. Decedent's Education (Specify on	If Yes, Give Year or Dates:		Decedent's Usual		kind of work done	Specify:	White s/Industry
136 hin 72 hou e. than "na:	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		J	orking life. DO NOT ${f etail}$	use retired)	Sa	les
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		17. Father's Name (First, Middle, Last)	rigan				r's Name (First, Middle, Fennema	Maiden Surname)	
212 ould be Menta mark	To Be	19a. Informant's Name/Relationship (T	-	19	b. Mailing Address			mber, City or Town, Sta	te, Zip Code)
MD and 2 sho alth and m 27 is aumati		John Edward Kerrig	gan/Father		0209 Ben		rive, Potor	nac, Maryla	
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	crema	tory or other place	)		L Baltimore	
altir mit. Pa partmer portan	Ì	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licen	⊶Alyson K		22. Name and	Address of Facilit	Cremation	Society of	Marylan
	_	23a. Part Enter the disease, or omo	cations that caused the	death Don			•	imore, Mary	land 21228 Approximate Interval
Physician /Medical		failure. List only one cause on ea						, 000, 011000, 101110001	Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conseque						
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseque	ence of):					
V, be isit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):			<u> </u>		
760, cate be executed physician and the burial - transit	Medical	X UNPENDED	AMENDED 23a,2	7,per	me,g919	9-21-11	sm		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth  4 Pregnant at time	6 -161-	2 Fetal death		ic pregnancy	23d. Date of delive Month	ery Day Year
P.O. Box 687: that the death certification of the attending detached for use as the strength of the strength o	Physician/	1 Yes 2 No 9 V Unknown	9 Unknown		Other (sp.				
is P.O.	<u>a</u>	Part II. Other significant conditions	contributing to death bu	it not resultir	ng in the underlyin	g cause given in P		tobacco use contribute es 2 No 3 Pi	to the cause of death?  obably 4  Unknown
Division of Vital Records, Italor Attending Physician: The law requires is after death.  al Director: After this certificate has been sighed in by the funeral director, page 2 should be	Completed						24a. Was	psy prior to	autopsy findings available o completion of cause of
Reco The law icate has	E						perf 1 <b>✓</b> Yes	ormed? death' 2 No 1 ✓	
Vital Rec hysician: The this certificate I director, page	Be		lospital:	2 FR/0	Outpatient 3	26.Place of Death	(Check only one)  Nursing Home 5	Residence 6 🗸 Ott	ner: Scene
ing Phys After thi uneral d	2	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year)		. Time of Injury	28c. Injury at Wor		how injury occurred	ion doone
ttendir death. ctor: A	ation	1 X Natural 5 Pending 2 Accident Investigati	on			1 Yes 2		_	
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not determined		- At home,	farm, street, factor	y, office building, e	etc. 28f. Location or Town,		Rural Route Number, City
the Hosp hin 24 ho the Fun	Medical C	29a. Certifier (Check only one) 2 Medical Examiner	an: To the best of my kr On the basis of examin						
To with Com	Me	29b Signature and title of certifier	and manner stated.		29	9c. License number	î	29d. Date signed (I	Month, Day, Year)
d		Cheel 2				O.C.M.E.		August 7, 2011	
Ø		30. Name and address of person who Ana Rubio MD. Assista	completed cause of deat nt Medical Examin			Street. Baltime	ore, MD 21223		
	ate	31. DAUG (0°9° 2011°)	32. Registrate						
Regist		ADISTI 9 ZIII I	Bullet II.	-3704					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2 0 1 2:40 **Arlene Everleigh** Palmer рм July Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Towson Baltimore Center 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Month, Day, July 30 1 □ M 2 🕅 F Months Hours Min. Year) 2011 Maryland **Director** Yrs. N/A Usual Residence of Decedent or 28a-f shov and Mental Hygiene.
Its marked other than "natural", or items 23a or 28a-f shorraumatic event, the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2951 Keswick Road 21211 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify. Specify. White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) N/A College (1-4 or 5+) N/AN/A Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ရ Derek William Palmer Karin Mo 1 z 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mother & 27 Derek & Karin Palmer/ Father 2951 Keswick Road Baltimore, MD 21211 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 5, 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place) injury 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2011 Glen Burnie, MD Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 Mael J. Flagle Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph\_sician/ RESPINATIONLY 4181 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) Day Pregnant at time of death detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No this certificate Hospital or Attending Physician: To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mannet of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) AUGUST 2011 xauero 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYUND. BIRENYAVIN GREATEN SALTIMONE MEDICAL CONTON

DHMH 17 Rev 7/2009

Registrar

AUG 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 25315 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:10 P™ Prock Aug. Helen N. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 110 Wakely Terrace Harford Bel Air Social Security Number If Under 1 Year I if Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Feb. 11, 1 □ M 2 👿 F Months Year)19<u>35</u> 109-28-2291 New Jersey 76 **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No MD Baltimore Timonium 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2514 Girdwood Road 21093 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MG4ST James M. Langelund Oda Nielson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tr Karen Barboza/Daughter 110 Wakely Terrace Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ⇟ Dulaney Valley 1 X Burial 2 Cremation 3 Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD Memorial Gardens 21. Signature of Funeral Service Lice 22 Name and Address of Facility Home of Dulaney Valley Flagle 10 W. Padonia Road Timonium, MD 21093 chael complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of) sician buria Physician/Medical phy: attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page or Attending Physician; The certificate 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No 4 Nursing Home 5 Residence 6 Nother Specific HUGHTERS HOH 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature ar 29c. License number person who completed cause of death (Item 23a) (Type, Print) State AUG 0 9 2011 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 11:10 PM Richard F. Quade, Sr. August 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arunde Glen Burnie Baltimore Washington Medical Center Age (In yrs. last birthday) 8. Date of Birth
July 1929, Year 1929 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number . Sex 1 Å M 2 □ F **Funeral** 397-24-7482 Months Hours Minnesota Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notitied at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Maryland Anne Arundel Pasadena 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 306 Kent Rd. 21122 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 Armed Forces?
1 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Year or Dates. 49-57 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Technician Manufacturing Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gustav Quade Frances Anders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys M. Quade / Wife 306 Kent Rd., Pasadena, Maryland 21122 Baltimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2011 Metro Crematory, Inc. Catonsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fune al Service Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph\_sician/ MyocArdinl IN FARCTION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) signed by the attending physician and de detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 1 L Yes should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No After this certificate has funeral director, page 2 s 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No မြ 1
Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation within 24 hours after death To the Funeral Director; 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 2 <u></u>3 <u></u> only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) travcis m D027415 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Washington Medical Center MP 32. Registra State

Registrar

U.

Richard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Reg. No. cedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City, Town 4c. County of Death or Location of Death **Funeral** birthday) If Under Date of Birth 9. Birthplace (State or Foreign M 2 - F Months Min Hours Director 53 214-74-632: Feb 01 1958 Maryland Usual Residence of Decedent 23a or 28a-f show "natural", or items 23a or 28a-f sho idical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2523 Madison Avenue Apt. United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2-X No Specify: 3 Widowed 4 Divorced Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) event, th Social Worker Health Care Be filed 17. Father's Name (First, Middle, Last) lith and Mental H 27 is marked of r traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) ဂ 1 and 2 should be Eugene Stone Julia Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Rodney Mosley /Brother 3832 The Alameda Baltimore, MD 21218 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . Page 1 ő ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Aug 0¢ 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 Signature of Funeral Service Licensee 22. Narcand Address of Facility Funeral Alternatives 4101443 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if a y, sacing to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of ohysician and the burial-transit resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No s been signed by the same should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an this certificate has autopsy performe prior to completion of cause of death? 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျှ 1 🗆 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this d in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 1 Tyes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 123a) (Type, Print) Hedital Courses 245 State

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Registrar

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State of Maryland / Department of Health and Mental Hygien 201 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Harry C. Rutter III August 6, 2011 7:15 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Future Care Cherrywood Baltimore Reisterstown Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Sep. 12, g. Birthplace (State or Foreign **Funeral** XXM 2 □ F Year) 930 Director 80 214-26-6171 Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d, Inside City Limits 1 Tes 2 X Xo MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Pleasant Hill Lane 21117 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

XXYes 2 \( \text{No} \) No ð 1 Never Married 2 X Married 1 ☐ Yes XX No Specify: 3 Widowed 4 Divorced Korea Specify: White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 P1umber Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louise Schmidt Department of Health and Meni Important: If item 27 is marke any injury or other traumatic Harry C. Rutter, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 Marian Jean Rutter/Wife Pleasant Hill Lane, Owings Mills, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial XXCremation 3 Removal from State Faiths ematory Other (Specify) 4 Donation 8/10/11 Manchester, MD Charie 1 Signature of June al Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 200 mm 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Chronic Obstructive Palmonary disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? cate has l autopsy 2 🗌 No 1 🗀 Yes Yes 2 Hospital or Attending Physician: ' 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ပ္ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending work' 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Nammord Mule 147683 8/9/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Miller 2835 Balhmore Smith Nonne Suite MA 21209 3 - Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

AUG 0 9 201

Baltimore, Maryland 21215-0036

Box 68760

P.O. I

Records,

**Division of Vital** 

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State of Maryland / Department of Health and Mental Hygiene

		1 - For State of Registrar Amend Items 23a, 26	per dr.,991	8 08/09/2011 Tificate of Death			1 25319
Physi	cian	1. Decedent's Name (First, Middle, Last)			2. Date of De Month	Day Yes 15 20	3. Time of Death 11 5:29 A M
/Med	lical	Regina Gertrude Rossing  4a. Facility Name (If not institution, give street and num		4b. City, Town, or Location of	July	4c. County of D	
Exam	iner	3601 Goldsboro Road	Del)	Ingleside		Queen	
Funera Directo			7. Age (In yrs. last birthday) 82 Yrs.		Min. Aug 3,	th 9.1 1928 N	Birthplace (State or Foreign faryland
pu »		Usual Residence of Decedent	10c. City. Town or Lo	agtion			10d. Inside City Limits
laryla shov	5	10a. State 10b. County  MD Wicomico	Salisb				1 ☐Yes 2X No
the N 28a-1	Director	10e. Street and Number	Ballsb	10f. Zip Code		10g. Citizen of What	Country?
with	Ë	31963 Buck Haven Court		21804		USA	
<b>Baltimore,</b> Maryland 21213-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modeal Event Inc. is the profiled at	by Funeral	1 Never Married 2 Married 1 Yes	2.♠No e	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 □Yes 2 🎇 No Specify:	in? (Specify Yes or No Puerto Rican, etc.)	14. Race - A Black, W Specify: W	
hour hour	ed	15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b. Kind of Busine	ess/Industry
CTS rin 72 rin "in	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-	'life i	kind of work done during most on NOT use retired)	of working		
Z1 Z with sid with year the er the	S	12 0	te	lephone operato			nication
be file	Be	17. Father's Name (First, Middle, Last)  Walter Bernard Mullen		18. Mother	's Name <i>(First, Middle</i> y Madeline	McIntyre	
ryla nould d Mer narke	은	<u></u>	10h Mailie	ng Address (Street and Number			te Zin Code)
Mal d2st d2st tth an tth an traur		19a. Informant's Name/Relationship (Type. Print)  Peter W. Rossing - son	0.66	)1 Goldsboro Ro	l; Henders	on, MD 216	40
Baltimore, Maryland 21215-UU36 bernit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any Injury or other traumatic event, the Modical Event		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from S  4 Ø Donation 5 Other (Specify)	20b. Place of Dispo		Date	20c. Location - City	
baltill permit. I Departm Importal any Inju	ouce	21. Signatur of Fun rus rive e ensee Ron 11 + S Wade	irector 22	2. Name and Address of Facility		•	
Time to		23a. Part 1. Poter the disease, of complications that ca shock, or heart failure. List only one cause on ea	aused the death. Do not ent				Approximate Interval Between
Physicia: /Medica	_	disease or condition resulting in death)	or as a consequence of):	lled Hypertens	ion		Onset and Death Years
Examine	r	Downstelly list on differen					
p .ti	iner.	Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury	or as a nonsequence of):				
recute and I-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	or as a consequence of):				
68760, ificate be executed g physician and as the burial-transit			57 45 4 501.004451.00 6.7.				
ficate g phys	edical	d					
Geath cert death cert e attending d for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outc 1 ☐ Live b 1 ☐ Live b 9 ☐ Unknown	ant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of Month	f delivery Day Year
_ % & %	含	Fait ii. Other significant conditions contributing to de	ath but not resulting in the u	nderlying cause given in Part I.			te to the cause of death?  Probably 4 Unknown
VItal Records, P.O. sician: The law requires that the certificate has been signed by the rector, page 2 should be detache	Completed				perf	opsy prior deal	e autopsy findings available r to completion of cause of th? Yes 2 🗷 No
	Be	25. Was case referred to medical		26. Place	of Death (Check only		
OT V Physic this ceral dire		Hospital:	npatient 2 ER/Outpatie			sidence 6 X Other	
On C ding P h. After i	in in	27. Manner of Death  1 Natural 5 Pending (Mont	of Injury 28b. Time o h, Day, Year) Injury	of 28c. Injury at Work?  M 1 □ Yes 2 □ N		how injury occurred	Residence
VISION Attention of the ector:	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place building	of Injury - At home, farm, sti ng, etc. <i>(Specify)</i>		28f. Location	(Street and Number o	or Rural Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir	Medical C		asis of examination and/or ir				
To the within To the	Me.	29b. Signature and title of Cetaffier		29c. License number		29d. Date signed (A	Month, Day, Year)
		11/10		D6374-	7	7/201	12011
		30. Name and address of person who completed cause	e of death (Item 23a) (Type,	Print)	1	1	1
		SEFFRON UKENY M	9 2	NO Centren	Me Ross,	Comment	e no 21615
	State Strar	31. Date filed (Month, Day, Year)	egistrar's Signature	extend			

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DHMH 17 Rev 1/2001

State Registrar BALTIMORE, MO

CARLIELA N. 120SAVES, 900 & CATON AVE

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31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9,11,12,15,16a&b,17&18 Per ANA BD G918 8/09/2011/JH State of Maryland / Department of Health and Mental Hygiene 25321 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July LARRY 31 2011 19:00 M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F June 22 <sup>Year</sup>1957 54 214-68-7365 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Potomac 1 🗆 Yes 2 🄀 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20854 7811 Scotland Dr. 12. Was Decedent Ever in U.S. UNX Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk Race - American Indian, Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates. Black, White, etc. 1 X Never Married 2 Married Specify. black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk 10 Ofice Work Government 17. Father's Name (First, Middle, Last) 411k 18. Mother's Name (First, Middle, Maiden Surname) James Archie Gland Eva Mae Rush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Taylor - niece 7811 Scotland Dr; Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state . Simuluro I Funeral Se vi Kuuallo S. Wade 22. Name and Address of Facility State Anatomy Board Director 655 W, Batlimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GASTRO INTESTINAL BLEEDING disease or condition resulting in death) Due to (or as a consequence of) EP515 Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of SCHEMIC that initiated events Due to (or as a consequence of) resulting in death) Last ALCOHOLIC LIVER /es, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X.No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide Investigation M 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiners once. Ph. sician/ Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

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Baltimore, Maryland 21215-0036

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29b. Signature and title of certifier

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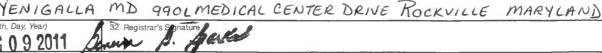
, or items 23a or aminer must be n

State Registrar

31. Date filed (Month, Day, Year) AUG 0 9 2011

Confeelle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25322 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sledz Sophia J. 2011 8:00 A M August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 2515 Reckord Road Fallston 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 12/28 1920 1 - M 2 - F 219-03-6893 90 Maryland **Director** Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Fallston MD Harford 1 Tyes 2 XXNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 2515 Reckord Road 21047 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Force 1 Ves 2 1 No 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 21 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2XXNo Specify. White Specify. 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home other traumatic event, the Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Kocun Anthony Andrew Raczkowski Bertha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 8507 Meadowsweet Road, Pikesville, MD Janet Huber (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 08/10/2011 Fallston, Maryland 4 ☐ Doynation 5 ☐ Other (Specify) Highview Cemetery 22. Name and Address of Facility Schimunek Funeral Home, Bel Air 21. Signay of Funeral Service Lit 21014 610 W. MacPhail Road, Bel Air, MD art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition simonis Medical resulting in death) Due to (or as consi quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or linjury Due to (or as a consequence of) Exami **so the Hospital or Attending Physician:** The law requires that the death certificate be executed and -tran: that initiated events Due to (or as a consequence of): resulting in death) Last sician a Physician/Medical Division of Vital Records, P.O. Box 68760 phys the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2, No 3 ☐ Probably 4 ☐ Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N page death? 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: \_2 🗖 No Other: 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Accident 5 Pending injury ours after death.

leral Director: Af

filled in by the fu 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) re and title of certifier 29d. Date signed (Month, Day, Year) Tall MID. 8/8 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar
DHMH 17 Rev 7/2009

State

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32. Registrar's Signate

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 20 25323 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Martin Leo Sorillo 15:22 bw AUJUSI ZOIL 4b. City, Town, or Location of Death 4a. Facility Name (II not institution, give street and number) 4c. County of Death Gi SINAI HOSPILA BAltimore timore ВA Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) Year) 1 M 2 □ F Months Days Hours 57 214-68-4892 Trinidad Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore 1 X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3804 Wabash Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 □ No 1 ☐ Yes 2X No SpecifyBlack Specify 3 Widowed 4 XDivorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Rosewood State Elementary/Secondary (0-12) College (1-4or 5+) Hospital 12th grade <u>Technician</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theophilus Sorillo Cynthia Reyes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1705 11936 Beltsville Dr. #15, Beltsville, Md Latoya Doster-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 8/10/2011 Owings Mills, Md 22. Name and Address of Facility
March F/H West re of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Par /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Atherosclepati Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ontributing to death but not resulting in the underlying cause given in Port I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ № 24a. Was an autopsy performed? 1 Yes 2 No 2 100 25. Was case referred to medical examiner? 2 No Hospital: 1 ☐ Yes 1 🗋 Inpatient 2 ER/Ou 28a. Date of Injury (Month, Day, Year) 28b. T

**Physician** /Medical Examiner Examiner

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, Its. 9008.

**Physician** 

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Examiner

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Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be

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tpatient	3 🗆 🛭	OOA	Other: 4  Nursing H	ome	5 Residence	6 ☐ Other (Spec		
ime of		28c.	Injury at Work?	28d.	Describe how inju	ury occurred		

1 Natural 2 Accident	5 Pending investigation
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined

28e. Place of Injury - At home, building, etc. (Specify)	farm,	street,	factory,	offic

ctory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)

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29b. Signature and title of	certifier/
) ( ) V	$\langle \langle     \rangle$

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c License number 29d. Date signed (Month, Day, Year)

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29a. Certifier

Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25324 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 130 AM Evelyn Mae Schofield 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Rosedale Baltimore FRANKLIN SQUASE HOSPITAL 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Funeral 216-50-3630 1 M 2 XF Months Hours Min. Aug. 8, 1947 Country) 63 Yrs **Director** Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State notified at Director Baltimore MD Essex 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n 21221 Funeral USA 139 Riverside Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Forces? Black, White, etc. ŏ 1 Never Married 2 Married þ 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 → Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry al Hygiene. Factory Worker Elementary/Seconday (0-12) College (1-4 or 5+) Brewery other traumatic event, Be Saltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of မ Richard Laubach June Hensler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is i 139 Riverside Road Baltimore MD 21221 Larry Edwards /son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 8/9/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fogeral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1/ Enter the disease, or complications that caused like death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ days Preumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** OPO evere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Exami and-trans Due to (or as a consequence of): resulting in death) Last physician ar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No Yes 2 4 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this hin 24 hours after death.

the Funeral Director: After thi
πpleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2, To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) or wholey, M.D. D70229 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Doratotaji 9000 FRANKLIN SQUARE DR Balto ind 21237 Danna

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene 25325 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:00 AM Derek Rauvain Stevens 100 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Saltimork If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Feb 2, Day 1964 Mary land **Director** 219-80-6140 Usual Residence of Decedent 23a or 28a-f shov 10b. County 10a. State ä 10c. City, Town or Location 10d. Inside City Limits Director or than "natural", or items 23a or 28a-f s the Medical Examiner must be notified MD Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 USA 2013 Oak Drive 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces

1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 12 bindery company binder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည should be Ruavain Stevens Christine Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Department of Health ar Important: If item 27 is any injury or other trau Christine Stevens - mother 2501 Violet Ave #906N; Baltimore, MD 21215 Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State cemetery, crematory or other place, 22. Name and Address of Facility State Anatomy Board Ronald S. Wade Director 655 W. Baltimore St; Baltimore, MD 21201 rent 1. Enter the dis-se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she, k, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ aucer ING Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nemia Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 FR/Outpatient 3 I DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 Certifying Numes Pranticiper To the best of my incomeday. Oceth occurred at the time, date and place, and out to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person leted cause of death (Item 23a) (Type, Print) 2401 W Belvedere Ave Balto, MARYLAND 21215

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25326 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 6,2011 Physician/ 12:25P Richard J. Tuscano Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. Gilchrist Towson 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Min 11-26-1927 Hours Maryland Director 83 214-20-5981 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland ral", or items 23a or 28a-f shorexaminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Middle River Md. Balto. 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21220 23 Terose Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian 11. Marital Status rmed Forces? Black, White, etc. 1 Never Married 2 Married by 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify. If Yes, Give Year or Dates 1946-1946 "natural". 3 XWidowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working ene. r than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Upholstery 8th Upholstery and Mental Hygier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic e once. Josephine Barbagallo Tuscano Guisippi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21236 Nottingham, Md. 4340 Hallfield Manor Drive Steven M. Tuscano 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 8-10-2011 Balto. Md. Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Schimunek Funeral Home 22. Name and Address of Facility Ste Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ sta disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 2 No Yes Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 Unknown Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s autopsy perform 2 **N**o 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျှ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28c. Injury at 28a. Date of injury (Month, Day, Year) I Director: After to in by the funeral 28b Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie Cert fying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one 29b. Sig 29d. Date signed (Month, Day, Year) D0071287 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Suite 4105, Balthure, Mudiday les 10 Jonth. Day. 32. Registrar's Signature State AUG 0 9 2011 Registrar

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Medic Examin		Melvin  4a. Facility Name (if not institut				4b. City, Town, o	r Location of De	August eath	4c. County	2ا( of Deat	
		University of M		edical	Center	Balti.	More If Under 24 F	les la B + + + E			N/A
Funeral Director		218-46-9055	6. Sex 1 M 2		n yrs. last birthday) 61 Yrs.	Months Days		lin. (Month, Di			thplace (State or Foreign untry)  NC
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ith the	ralD	10e. Street and Number 2635 Chesterfield	ΙΛνο			10f. Zip Code	21213		10g. Citizen of	What Co	
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d 2 sho alth and 27 is n	- 1	19a. Informant's Name/Relation  Mary Townes	onsnip ( <i>Type, Print)</i>			-		Rural Route Numb Baltimore, I	-	State, Zip	o Code)
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a, Method of Disposition	on 3 🗆 Removal fr		20b. Place of Dispor	sition (Name of natory or other plac		Date		- City or Town, State	
nit. Page 1 artment of ortant; If i injury or or	8	4 Donation 5 Othe	4 ☐ Donation 5 ☐ Other (Specify)  1. Sign for a Funeral Service Licensee				ss of Facility	ug 05, 2011	W	ndso	r Mill, Md.
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The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pi	ve Birth 2 L regnant at tin nknown	Fetal death 3 me of death 5	Other (specify)	<u></u>		Me	onth	Day Year
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<b>&gt;</b> S	To B	examiner? 1  Yes 2 No			2 ER/Outpatien	t 3 🗆 DOA Oth	er: 4 🗆 Nursin	g Home 5 ☐ Res	dence 6 🗆 Oth	er (Spec	ify)
Attending Physician: or death. ector: After this certific by the funeral director.	cate:	27. Manner of Death  1 ☑ Natural 5 ☐ Per 2 ☐ Accident Inve		ite of injury onth, Day, Ye	(ear) 28b. Time of injury	28c. Injun work M 1 🗆	y at :? Yes 2 □ No	28d. Describe	how injury occur	red	
r Atter ter dea rector 1 by the	Certificate	3 Suicide 6 Cou	uld not be 28e. Pla	ice of Injury -	- At home, farm, stre Spec <i>ify</i> )	et, factory, office		28f. Location (		er or Ru	ral Route Number,
To the Hospital or Attending Physicial 24 hours after death. To the Funeral Director: After th completed filled in by the funeral		29a. Certifier 1 <b>Certify</b>	ing Physician: To the			coured at the time	date and place			er as sta	ated
the Hospital hin 24 hours the Funeral mpleted filled	Medical	(Check 2 🔲 Medica	al Examiner: On the ling Nurse Practions	oasis of exam	nination and/or invest	igation, in my opinic	on, death occurr	ed at the time, date	and place, and du	e to the	cause(s) and manner stated.
To t with To t		29b. Signature and title of certi	fier	M.D.		29c, License	number 527		29d. Date signe		
		30. Name and address of person			h (Item 23a) (Type. P		.061		August	- 1,	, 2011
		Timothy P. Ph. 31. DAUG 1079 2019					Balti	more, N	ID 212	01	
Stat Registra		** AUG 0'9 2011	" Denous 32	. Registrar's	Signature						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ homas 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore** Future Care-Charles Village 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 M 2 Z F Months Days Hours Min. 216-20-0007 84 **Director** Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location Director **Baltimore Baltimore City** 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21217 1007 West Lanvale Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black ☐ Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Nursing Home Nurse Assistant** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Francis Butler Joseph Butler Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
 2116 Catskill Street Temple Hills, MD 20748 19a. Informant's Name/Relationship (Type, Print) Maxine Bernett 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Lansdowne, Maryland Aug 06, 2011 Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signatur of F eral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Yes the Funeral Director: After this certific pleted filled in by the funeral director, 25. Was case referred to predical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City'or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed, (Month, Day, Year) 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sutin Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25329 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death amonth Physician/ NODAK ELIZA BETH 8:25 PM 2011 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Burnie Anne Arunde Center **Funeral** If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Sept. 11 Year) 1944 Massachusetts 1 □ M 2 ⋤ F Months Hours Min 460-68-4323 Director 66 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3932-A Germantown Road 21037 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Specify: Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry Medical Doctors (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Office Medical Billing Specialist Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be 1 Charles M. Bunner, Sr. Margaret Ε. LeBlanc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , Page 1 and 2 s' ment of Health a Important: If item 27 any injury or other tra Carl E. Lindblom, Jr. / Son P.O. Box 687, Edgewater, Maryland 21037 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 08/05/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Road, Baltimon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 299 Frederick Road, Baltimore, Maryland 21228 shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Onset and Death SEPTIC SHOCK Medical resulting in death) Due to (or as a consequence of) Examiner TRACT INFECTION URINARY Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury ACUTE Hospital or Attending Physician; The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical LOSTRIDIUM DIFFICILE INFECTION Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an cate has page 2 s autopsy performed 2 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes ည 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my kin, which you are not place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my kin, which you are not place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

08 | 04 | 20 | | 00041284

Registrar

BALTIMORE WASHINGTON MEDICAL CENTER

who completed cause of death (Item 23a) (Type, Print)

Registrar' gnatu

CABARROS

RAYMUN DO

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Bay 20 Ten 7:16a Arry. **Physician** James Vaughn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Somerset Crisfield Edward W. McCready Memorial | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March 1 5 , 1 9 4 5 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 **X**M 2 □ F 66 215-40-4657 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2X No Crisfield MD Somerset Director 10f. Zip Code 21817 10g. Citizen of What Country? 10e. Street and Number USA 26689 Mariners Road death Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Black, White, etc. filed within 72 hours after ( Hygiene, 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: White 3 Widowed 4 Divorced Year or Dates: er than "natur , the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Northeast Foods Truck Driver 12th permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygid Important: If Item 27 is marked other any injury or other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jelema Edward Vaughn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26689 Mariners Road Crisfield MD 21817 Shirley Vaughn /wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/10/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens 300 Mace Ave. Balto. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Connelly Funeral Home of Essex 21221 Immediate Cause (Final loyrs Physician theroschero cerdiovascular disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner nlawan abetes Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of law requires that the death certificate be executed burial-transit Exami Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 1□ Yes Attending Physician: After this certification funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 KER/Outpatient 3 DOA မှ 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director A completely filled in by the fu dea h. 2 Accident Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00047426 2011 ermb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ER Cusfield, MD Mc Cready 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Matthew Richard Walker, Sr. 05, 2011 7:11 P. M August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County Timonium Stella Maris Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Days 218-26-3477 80 Auq. 07, 1930 Baltimore, MD. Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at with the Maryland Director 1 🗆 Yes 2 🏲 No Timonium Maryland Baltimore County 10e. Street and Number 10f. Zip Code Citizen of What Country?
United States ō 21093 Funeral "natural", or items 23a 2422 Westridge Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ed Forces Black, White, etc. X Yes 2 No Korean 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 H No Specify White If Yes, Give Conflict Specify: Completed 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed, Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Accounting Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Alice Walsh ၉ John Thomas Walker and l 19a. Informant's Name/Relationship (Type, Print) (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **2422 Westridge Road Timonium, Maryland 21093** 2422 Westridge Road Mrs.Suzanne(nee Auman)Walker Health tem 27 Baltimore, 20a. Method of Disposition cation - City or Town, State (Harford County) 20b. Place of Disposition (Name of Monday Aug. 08, 2011 ☐ Burial 2 Cremation 3 ☐ Removal from State Evans Funeral Cratel and 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Cremetion Services, Inc. Signature of Funeral Service Licensee Jeffrey L.Gair, Sr. 079 2 Name and decrees of Facility Services Funeral and Cremation Center, P.A.

Lic. #M0067/ 2325 York Road Timonium, Maryland 21093-2215 Timonium, Maryland 2325 York Road 23a. Oart 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate erval Between Onset and Death mediate Cause (Final Physician/ BLADDER CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) inding physician and use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 by the attending stached for use as IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No has filled in by the funeral director, page 2 this certificate 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: မ 2 X No 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No X Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 ho

To the Fune

completed 1 (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

AUGUST

MATTHEW WALKER

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JUNECIA WHITE

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2011 11:37a <sup>™</sup> FRENCHOLA WATTS Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death N/A 2210 KOKO LANE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1924 1 □ M 2**XX**F (Month, Day, 10) Director 87 MARYLAND 212-22-4849 Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2210 KOKO LANE 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give "natural", or iten ledical Examiner r 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: BLACK 3 X Widowed 4 □ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) FOOD SERVICE llth grade CAFETERIA MANAGER Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY E. SCOTT PERRY JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4606 Ft. Totten Dr. N.E., Wash., D.C., 20011 Vernon G. Chase/Son altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XXurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ARBUTUS MEMORIAL 08-10-11 BALTIMORE, MARYLAND 21. Signal e of Fungral Service Lipersee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE, BALTIMORE, MARYLAND 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Houte Muele mandiffic beckem-4
Due to (or as a consequence of): Physician/ Acute disease or condition Mas Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Funeral Director: After this certificate a steed filled in by the funeral director, pag 1 Yes 2 No 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home Residence 6 Other (Specify) 22 No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certifier

Registrar

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

AUG 0 9 2011

D0033330

3373 N. Calvert Ir Bully, 11/1. 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25333 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 7:54 P M Whitlaw Marcella Margaret August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Bel Air 218 Meadow Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Davs (Month, Day, Year) Sept. 27. 397-28-1514 79 Wisconsin **Director** 1931 Usual Residence of Decedent r 28a-f show notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral United States 21014 218 Meadow Road items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Was Decedon. Armed Forces? ¹ ☐ Yes 2 X No "natural", or iter Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Federal Government/ is marked other than Elementary/Seconday (0-12) Medical Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Schroeder Schoenike Elsie Page 1 and 2 should be ment of Health and Ment Fredrick 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21014 27 Joseph Thomas Whitlaw, Jr. 218 Meadow Rd., Bel Air, MD Department of Healti Important: If item 2: any injury or other to once, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burlal 2 Cremation 3 Removal from State Uniformed Sers. Univ. 08/05/2011 Bethesda, MD 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00382 Rapp Funeral and Cremation Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20910 933 Gist Ave., Silver Spring, MD Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULA Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Month Year Pregnant at time of death P.0. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law autopsy page 2 this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of 28c, Injury at work?
1 Yes 28d. Describe how injury occurred After Natural iniury 5 Pending 2 🗆 No Accident Investigation completed filled in by the 24 hours after deat Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) 30. Name and a

Registrar

State

Date filed (Month, Day, Yea AUG 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G918 8/22/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar 25334 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death webster Year Physician/ Month Bernade He 7:10P August 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Seasons Hospice Randallston Baltimore Social Security Number 7. Age (In yrs. last birthday) 39 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country)
 MD **Funeral** 214-86-1542 1 - M 2 X F Hours **Director** 05-02-1972 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland at Director MD must be notified Harford Edgewood 1 Yes 2 No 10f. Zip Code 21040 10e. Street and Number 'n 10g, Citizen of What Country? 23a ( Funeral 623 Burlington Ct USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. if Health and Mental Hygiene. item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Food Service Elementary/Seconday (0-12) College (1-4 or 5+) Cook 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lester Webster Margaret Morgan 19a. Informant's Name/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 623 Burlington Ct Edgewood MD 21040 Lisa Marshall Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of h Important: If ite any injury or ot 7=18=20 8/15/2011 1 Burial 2 X Cremation 3 Removal from State Hanover MD Ardent Crem. 4 Donation 5 Other (Specify)  $^{22.\, ext{Name}}$  and Address of Facility  $ext{Phillip}$ Weatherford ore MD 21213 Signature of Funeral Service Licensee 2431 E Oliver St Baltiore MD 23a. Part 1. Enter the disease, or complications that clusted the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Cancer Physician/ Lung Metastatic Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Be Completed by Physician/Medical Examiner Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Other: 1 🗌 Yes 2 🗹 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N 5 RAMPAKE 1MID 2535 SMITH AV

ns Rujapahnemio

29b. Signature and title of certifier

2

Division of Vital Records, P.O. Box 68760

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00057465

5-203

29d. Date signed (Month, Day, Year)

MD 21209

8/5/11

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 25335
State of Maryland / Department of Health and Mental Hygiene

		1- For State Crivial yiand / Depart Registrar	ificate of Deat			eg. No.	
Physicia Medical Exami		Decedent's Name (First, Middle, Last)			Date of Dear     Month	Dav Year	3. Time of Death 1845 hrs
- Carlo	IIGI	Richard Walters  4a. Facility Name (if not institution, give street and number)	4b. City.	Town, or Location	August 4,	2011 4c, County of D	
		Baltimore Washington Medical Center		Burnie		Anne Arun	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	.,				. Birthplace (State or oreign
Director		220-84-3456 1KM 2_F 35	Yrs. Month	ns Days Hours	Min. April	9, 1976	Country) Maryland
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, T	own or Location				10d. Inside City Limits
<b>.</b>	_		Burnie				1 Yes 2 No
Maryland <b>28a-f shrw</b> d at once.	Director	10e. Street and Number	10f. Zip	Code	10	0g. Citizen of What	
e e	Dir	103 Elm Ave	210	61		USA	
h with ti ms 23a be noti	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 V Never Married 2 Married Armed Forces?			gin? ( Specify Yes or No., Puerto Rican, etc.)	- 14. Race - A White, et	merican Indian, Black,
r deat	Fun	1 Yes 2 X No					ic.
rs afte	by	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 1	1 Yes 2 6a. Decedent's Usual	Occupation (Give		Specify: 16b. Kind of Busine	White
5-0036 led within 72 hours after Hygiene. Inther than "natural", the Medical Examine.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of wo			TOD. Taria of Edonic	ooo madda y
036	Пp	11	Server			Hospital	ity
filed v	-	17. Father's Name (First, Middle, Last)			's Name (First, Middle, N	faiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked nther thau	o Be	Richard Eugene Walters, Sr.  19a, Informant's Name/Relationship (Type, Print)	19b Mailing Address	Lou .	Ellen Davis nber or Rural Route Num	her City or Town 9	State Zin Code)
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked nither injury nr nither traumatic event, the Metal Info	٦	Lou Ellen Payton/ Mother			Burnie, MD		rate, zip oode,
L and Healt fitem		20a. Method of Disposition 20b. Pla	ice of Disposition (Nar matory or other place)	ne of cemetery,	Aug Date 11	20c. Location - Cit	y or Town, State
MOI Pages sent of unt: I		1 XBurial 2 Cremation 3 Removal from State Glen 4 Donation 5 Other Specify:	Haven Mem	. Park	2011	Glen Bur	nie, MD
Baltimore, permit. Pages 1 a Department of He Impartant: If ite	- 17	21. Signature of F eral ice Ucensee	22. Name and	Address of Facility	Singleton	Funeral&	Cremation
		SMO 1- Danielle 1901319	Servic	es PA 1	2nd Ave Sw	Glen Burn	ie, MD 21061
Physician /Medical		23a. Part I. Emily the disease, or complications that caused the death. D failure. List only one cause on each line.			ardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Heroin and coca Due to (or as a consequence of):	ine Intox	ication			Deatri
	.	Sequentially list conditions, b					
	mine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause					
gt q	Exam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
executed an and al - trans		d.  AMENDED AMENDED 23a, 27, 28	o f nor mo	~010 0	17 11 om		
760, irate be executed by physician and the burial - transit	Medical			,g510 0-		Lood Bate of the	
rtificar ing ph		23b. Was decedent pregnant in the past 12 months?	2 Fetal death	3 Ectopic	pregnancy	23d. Date of deli Month	Day Year
Box 687 s death certific the attending p	Physician/	1 Yes 2 No 9 Unknown Pregnant at time of death	5 Other (Spec	cify)			
D. B. trhe de by the		Part II. Other significant conditions contributing to death but not resu	alting in the underlying	cause given in Pa	rt I. 23e. Did to	bacco use contribute	e to the cause of death?
P.O. res that to signed by be detact	d b				1 Yes	2 No 3 1	Probably 4 🗹 Unknown
Records, The law require ficate has been si page 2 should b	Completed		·		24a. Was a		e autopsy findings available to completion of cause of
ecc he lav ate has	E				perform	med? deatl	h?
tal Re	B B	25. Was case referred to medical examiner?		26.Place of Death			
Division of Vital ral or Attending Physician: rs after death.  al Director: After this certiced in by the funeral director.	2	1 Yes 2 No Inpatient 2 Y EF		OA Other			ther:
n of ding Pl h. After	Ë	1 Natural (Month, Day, Year)		ßc. Injury at Work 1 Yes 2 🕱		ow injury occurred	ť
Atten Atten or deat rector by the	<u>izati</u>	2 Accident Investigation 28e Place of Injury - At hom	Ed 6:06 pm			treet and Number of	r Rural Route Number, City
Div	Certification:	Suicide  Sui	•	, omeo Danaing, ax	or Town, St	ate) 103 Elm rnie, Md.	
0 - = >		29a. Certifier 1 Certifying Physician: To the best of my knowledge,			ce, and due to the cause	e(s) and manner as	
To the Ho within 24 h To the Fu	Medical	one) 2 Medical Examiner: On the basis of examination and/ and manner stated.			curred at the time, date a		1
× .	2	29b. Signature and title of certifier	29c	O.C.M.E.		29d. Date signed (	
wd		30. Name and address of person who completed sause of death (Item 23	(a)	J.J.IVI.L.		August 5, 201	
4	1	Melissa Brassell, MD Assistant Medical Examiner		nore Street, Ba	altimore, MD 2122	3	1
Sta	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature					
Regist		AUG 0 9 2011	noted .				
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DHMH 17 Rev 1/2001 OCME 2006

OUNE

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atrick Xavier V		State of Maryland / Department of Health  - For State  Certificate of Death		ygiene	2011	25338		
Physic Medical Exam	an/	Registrar  1. Decedent's Name (First, Middle,Last) PATRICK XAVIER WARD		2. Date of Death Month August 5, 2		3. Time of Death 2139 hrs		
		Upper Chesapeake Medical Center Bel Air	n, or Location of Death		4c. County of Death Harford			
Funeral Director		219-15-6319 1 M 2 F 29 Yrs.	Year If Under 24Hrs Days Hours Min		Foreign	n '		
Maryland 28a-f show any 1 at once.	tor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location           MD         HARFORD         BEL AIR				10d. Inside City Limits  1 Yes 2 No		
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	al Director	10e. Street and Number         10f. Zip Co           962 REDFIELD RD APT H         2101	4		USA			
P 6 8	by Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Co	of Hispanic Origin? (Spuban, Mexican, Puerto  No specify:	Rican, etc.)	201 253  g. No.  Day Year 2011 3. Time of Death 2139 hrs  4c. County of Death Harford  (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD  10d. Inside City Lin 1			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygens. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working DISABLED	g life. DO NOT use reti	red)	DISABLED	ndustry		
rod oth	Be Co	17. Father's Name (First, Middle, Last) WILLIAM WARD			,			
MD 21.2 d 2 should b. Jth and Ment n 27 is marl	To	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (S	Street and Number or I					
Ce, M 1 and 2 Health Fitem 2		20a. Method of Disposition 20b. Place of Disposition (Name of						
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Departion 5 Other Specify:						
Balt permit. Depart Import	. I		dress of Facility SCH ACPHAIL RD					
Physician /Medical <i>E</i> xaminer		23â. Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dy failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Sharp Force Injuries  Due to (or as a consequence of):	ying, such as cardiac c	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death		
d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last b. Due to (or as a consequence of):	- 1					
e executed cian and rial - transit	ical	d.  UNPENDED AMENDED						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Physician/Med	FFEMALE: 23c. If yes, outcome of pregnancy   1	ncy		ay Year			
ords, P.O. Be v requires that the de s been signed by the should be detached f	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	use given in Part I.					
Records, P.O.  The law requires that th fracte has been signed by , page 2 should be detach	Completed			24a. Was ar autopsy perform 1 Yes 2	prior to co ned? death?	ompletion of cause of		
Vital Rechysician: The this certificate director, page	To Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA	Other Nursin		tesidence 6 Other:			
Division of Vital is low Attending Physician: 15 after death.  al Director: After this certiled in by the funeral director		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 2 Natural 1 Nestigation 2 Natural 2 Natural 2 Natural 2 Natural 3 Natural 3 Natural 3 Natural 3 Natural 3 Natural 4 Natural 4 Natural 5 Natu	Injury at Work?  Yes 2 ✓ No	28d. Describe ho Subject assa				
Divisior  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Multi-Family Apt.		or Town, Sta 962 Redfield Ro	oad Apt H, Bel Air, M	D		
o the Ho ithin 24 o the Fu	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opi and manner stated.						
H 3 H 8	Me	29b. Signature and title of certifier 29c. Lic	cense number			th, Day, Year)		
<b>\</b>		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Stre	et, Baltimore, MI	21223				
S Regis		31. Date filed (Month, Day, Year)  AUG 0 2011				*		

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

## **VOID**

# CERTIFICATE #

2011 - 25337

### SEE

## **CERTIFICATE** #

2011 - 24 527

Shirtoy Womack

Completed 8-242011 Ws.

Please Type or Print in Black Indelible Ink 5 Fraure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25338 Certificate of Death 1. Decedent's Name (First, Middle, Last) Arthur Wagoner Sr. 2 Date of Death Year Physician/ Month WALTONER Pay SEP M ARTHUR TULL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore ENVOY OF Pikesville pikesville Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Date of (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Hours Min. Vrs Director 217-09-0528 96 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Baltimore Pikesville 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n Funeral Sudbrook Lane 21208 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, I Hygiene. other than "natural", or iter rent, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: 3√ Widowed 4 □ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Guard na Waxter Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o မ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or care. Cosby Wagoner Viola Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Gross-Daughter 4012 Carthage Road, Randallstown, Md Baltimore, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Donation 5 Other (Specify) King Memorial Park 8/5/2011 Woodlawn, Md 21. Sigi of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 300 Wabash Ave, Baltimore, Md 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartifalure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cardiac amythemias disease or condition 5 MINLES Medical resulting in death) Due to (or as a consequence of): Examiner Atheroscienche heam disease 15 425 Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on 11 Exam Hypertension and -tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Conyestive heart deilling 545 certificate be Box 68760 the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) n the past 12 months? Month ☐ Pregnant at time of death ☐ Unknown 1 Yes 2 9 Unknown 2 No the P.O. I signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 🗹 No this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director; After this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P84 D30494 8-1-2011 K DESHIM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K-DESHIM contonsvillemo 2/228 Maiden charce lane 31. Date filed (Month, Day, Year, 32. Registrar's Signature State AUG 0 9 2011 Registrar

DHMH 17 Rev 7/2009

		For						delible Inl 18,08/09/ tificate of L			_		_	25	339
		State Registrar  1. Decedent's Name					Cer	tificate of l	Death		2. Date of Dea		2011		
Physicia			W. Watk		Ι								2011 Year		of Death  5 PM M
Medic Examin	_	4a. Facility Name (if	not institution, (	give street an	d number)			4b. City, Town, o	r Location	of Death		$\neg$	c. County of Death		
			Washing					Fort Wa					rince Ge		
Funeral Director		5. Social Security No. 579-96- Usual Residence of	1209	5. Sex 1 X M 2 [		e (In yrs. Ia 45	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birt (Month, Day July 6		Cou	iplace (State ntry) ingto	
show dat	ē	10a. State	10b. County			10c. City	y, Town or Lo	cation						10d. Inside	City Limits
Maryl 28a-f otifie	Director	MD	Prince	Georg	e's	Fo	rt Was	hington						1 🗆 Y	es 2 No
s 23a or	Funeral D	10e. Street and Nun		2				10f. Zip Code 20744					10g. Citizen of What Country?  USA		
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	اھ	11. Marital Status  1 🔯 Never Marri		Arm	Decedent Bed Forces? Yes 2 1		- 11	<ul> <li>13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> <li>1 ☐ Yes 2 ▼ No Specify:</li> </ul>					14. Race - American Indian, Black, White, etc.  Specify: black		
ours a	eted	3 Widowed	4 L Divorced	Year	or Dates.			Decedent's Usual Occupation					16b. Kind of Business Industry		
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l withir ygiene her th t, the			12		4	,+,		troubleshooter				electronics			
e filec ntal Hy ed otl	To Be		17. Father's Name (First, Middle, Last)  John William Watkins II						18. Moth		(First, Middle,		Surname)		
ould b							10h Mailin	a Address (Street	and Numbi		an Eva:		r Town, State, Zip	Code)	
d 2 sh alth ar 1 27 is er trau			atkins/n					Haras P.					744		
ge 1 an it of He If item or othe			☐ Cremation 3			C		sition (Name of natory or other plac	ce)	D	ate	20c. l	_ocation - City or	Town, State	
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6 5 5	lical Examiner	shock, or hear Immediate Cause ( disease or conditio resulting in death)  Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nt failúre. List on Final in nditions, imediate rlying iinjury s	a. Di	on each line	e. archi a consequ + enca a consequ	al T	ntarction	00					Approxim Interval E Onset an	etween
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	Completed by Pr	Part II. Other signif		s contribution	-	out not res	ulting in the u	nderlying cause gi	ven in Part	:1.	1 🗆	Yes 2 an osy ormed?	death?	obably 4 opsy finding ompletion o	M Unknown
an: Th tifficate or, pa		25. Was case referre	ed to medical	1				26 Pl	ace of Dea	ath (Check	1  Yes	2 🗷 1	No 1 ☐ Yes	2 No	
nysicia iis cert direct	일	examiner? 1 X Yes 2	□ No	Hospital:	1 🗆 Inpati	ent 2 🔀	ER/Outpatien	Oth	er:			dence	6 ☐ Other (Speci	fy)	
ending PF sath. nr. After th	Certificate	27. Manner of Death  1   ↑ Natural  2   Accident	5 Pending Investiga	ition	Date of inju (Month, Day		28b. Time of injury	28c. Injur work M 1	y at <br Yes 2 [		8d. Describe h	iow inju	iry occurred		
tal or Atter safter de al Directo ed in by tl		3 ☐ Suicide 4 ☐ Homicide	6 U Could no determin	28e.	Place of Injubul	ury - At ho c. (Specify,	me, farm, stre )	eet, factory, office		2	28f. Location (Street and Number or Rural Route Number, City or Town, State)				mber,
he Hospi iin 24 hou he Funer ipleted fill	Medical	(Check 2 only one) 3	☐ Medical Ex ☐ Certifying N	aminer: On t	he basis of e	xamination	and/or invest	igation, in my opinio	on, death o	occurred at 1	the time, date a	ind plac	and manner as sta e, and due to the c e(s) and manner as	ause(s) and i	manner stated
Nith Con Con Con Con Con Con Con Con Con Con		29b. Signature and	title of certifier	8	26	٥	40 ~	29c. Licens	e number	-6			ate signed (Month		
		30. Name and addre		no completed	d cause of d	eath (Itela	23a) (Type, P								
		11701	Living	ston	Rd.	#30	09 F	ort Wa	shing	ton	WB				
State Registra	-	31. Date filed (Monti	AUG 09	2011	22 Hegistra	ars Signat	8. pa	rint) OFF Wa							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25340 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Mugust Physician/ Year 201 Vonel Woinqust 06:00 R.M Kensey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner sattimore gnes Health Care 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 □ M 2 😾 F Director 217-40-8863 69 25 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MDNA Baltimore X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3705 Flowerton Road 21229 U.S.A. items ; death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force o 1 Never Married 2 Married 72 hours after Completed by ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: If Yes Give Specify: Black 'natural", 3 X Widowed 4 Divorced Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clerk 2th grade Clothing Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve ဂ္ Charlie Roundtree Lewis Ada Drye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3705 Flowerton Road, Baltimore, Md 21229 Sherrie Wonigust-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State nation 5 Other (Specify) 8/9/2011 Arbutus, Md Arbutus Memorial 21. Sigr ture N Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ CANCER METASTATIL BNAIN unknown disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Lung Cancel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami death certificate be executed ician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 🗌 Yes 2 🗌 No 3 🔲 Probably 4 🕽 🔊 nknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 1 No Yes 2 2 No 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Hospital 2000 ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🔲 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 750293 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital BACTMORE MARTCAND

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 4, 2011 4:02 P. M Jovce Ward Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A Examiner 4b. City, Town, or Location of Death 1325 Bolton Street Baltimore Social Security Numbe **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Nov . 18, 9. Birthplace (State or Foreign Days Hours 217-26-1930 1 M 2 X F 81 Mary Land Director Nov. Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at anotes. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/ABaltimore 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1325 Bolton Street 21217 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ò 1 Never Married 2 X Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Graham McCartney Lucille Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1325 Bolton Street, Baltimore, Maryland 21217 Thomas Ward Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donator 5 Other (Specify) Atlantic Crematory or other place) Glen Burnie, Maryland 8/6/2011 21. Signatul of Juneral Service Lice 22. Name and Address of Facility Rurgee Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Martimore 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Primaux Onset and Death enituneal Cancinoma Physician/ len muntip Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ξō 5 Other (specify) Dav detached the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 XNo 3 Probably 4 Unknown Completed 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate i completed filled in by the funeral director, page 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar Date filed (Month, Day, Year) AUG 0 9 2011

DHMH 17 Rev 7/2009

son who completed cause of death (Item 23a) (Type, Print) Charles Street

Towson, Maryland 21204

11-05813 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. O'Nethea Kenyel Ward State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death O'Nethea Kenyel Ward 2055 hrs **Medical Examiner** August 2, 2011 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Johns Hopkins Hospital **Baltimore** 5, Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. **b**6 Director 01 2011 N/A 1 .4 2 X F Country) Yrs Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County Baltimore MD NA 1 X Yes 2 No narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once, Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 U.S.A. 3923 Mount Pleasant Ave Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Black δ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 Pages 1 and 2 should be filed within 72 Page 10 Filed by the file of the f N/A N/A N/A N/A 17, Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Crystal Geathers t: If item 27 is marked other traumatic event, f Ned Ward Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e) 21224 3923 Mount Pleasant Ave, Baltimore, Crystal Geathers-Mother 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State B/8/2011 Baltimore, Md On-Site 4 Donation 5 Other Specify: in ature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West Baltimore, 4300 Wabash Ave, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death a Complications of Prematurity Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical AMENDED 23a, 27, per me, g920 10-7-11 sm attending physician of use as the burial -X UNPENDED Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown signed by the a I be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed s been s 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? 2 No certificate ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 ✓ Inpatient 2 Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 26d. Describe how injury occurred 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined (Specify) Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E August 4, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ling Li, MD

Registrar's Signature

ORIGINAL

State Registrar

31. Date filed (Month, Day, Year)

AUG 0 9 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25343 For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0045 Month Jul 30, a2011 **Beverly Walker** Physician/ Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Randalistown Seasons Hospice of Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Funeral (MODEC 12, 1961 1 □ M 2**X** F 49 213-86-4784 Director Usual Residence of Decedent 10d. Inside City Limits
1 ☐ Yes 2 ☐ No ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director **Baltimore Baltimore City** MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 21213 Funeral 3908 Erdman Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No and 2 should be filed within 72 hours after death 11. Marital Status Black, White, etc. Black 1 Yes If Yes, Give 1 Yes 2 No Specify: δ 1 X Never Married 2 Married Maryland 21215-0036 Specify: 'natural", 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates 16b. Kind of Business Industry traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education Give kind of work done during most of working life. DO NOT use retired)

Employee (Specify only highest grade completed) I Hygiene. other than " Flower Shop Elementary/Seconday (0-12) College (1-4 or 5+) 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Walker r and Mental ? John Walker ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3627 Elmora Avenue Baltimore, MD 21213 19a. Informant's Name/Relationship (Type, Print) Charisma Pearson Health tem 27 i other Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Carmel Cemetery 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot . Page 1 Baltimore, Md Aug 04, 2011 4 Donation 5 Other (Specify) 21. Signature of Euperal Service Licensee 22. Name and Address of Facility Estep Brother's Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 any inj once, death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2V/A CWT Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_ Month Day Year in the past 12 months? Pregnant at time of death the g Unknown g 🗌 Unknown ò 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed b should be deta by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Cher (Specify) Land 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 1 Yes 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Manner of Death Certificate: work? 1 \( \text{Yes} \) 2 \( \text{No} \) within 24 hours after death. To the Funeral Director: After (Month, Day, Year) injury 1 Natural 5 Pending M Investigation Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completed (Check only one) 29b. Signature and title of certifier 30, 201) 037575 ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed MD Ave 602/2 Z&35 MA 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			- State Registrar Amend Item 2	State of Mary 23a per dr.	dand/Do	partment of Heal 08/09/2011 dhb Certificate of Deat	th and Mental I th	Hygier Reg.	2011	25344	
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)  Catherine	A. Yuc	ka		2. Date of Month		Day H 2011	3. Time of Death	
	Medic Examin		4a. Facility Name (if not institution, give st	reet and number)	ка	4b. City, Town, or Locat			4c. County of Death		
	<u></u>		Union Memorial 5. Social Security Number 6. Sex		um land blodba	Baltimor		Dist	a Pint	-10	
	Funeral Director		5. Social Security Number 6. Sex 219-42-9975 1 Usual Residence of Decedent		yrs. last birtho	Months Days Hou				nplace (State or Foreign Tyland	
	yland f show ed at	tor	10a. State 10b. County		c. City, Town o					10d. Inside City Limits	
	r 28a- notifie	Director	Md.  10e. Street and Number		Balti	more City		10-	Citizen of What Cou	1 😾 Yes 2 🗆 No	
	with the s 23a o	Funeral	3113 East North	ern Parkw	ay	21214-14	21		U.S.A.	andyr	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No lif Yes, Give Year or Dates.	in U.S.	<ul><li>13. Was Decedent of Hispanic If Yes, specify Cuban, Mex</li><li>1 ☐ Yes 2 No Spe</li></ul>		No-	14. Race - Amer Black, White Specify: Wh	, etc.	
15-0	72 hou n "natu ledical	Completed	15. Decedent's Edu (Specify only highest grade	completed)	1 (0	ecedent's Usual Occupation live kind of work done during in e. DO NOT use retired)	most of working		. Kind of Business I rd Balt		
212	within giene. er thar , the N		Elementary/Seconday (0-12)	College (1-4 or 5+)		inistrative	Assistan		pital		
Baltimore, Maryland 21215-0036	should be filed and Mental Hy Is marked oth raumatic event	To Be	17. Father's Name (First, Middle, Last) Peter Dellafic	ora		· · · · · · · · · · · · · · · · · · ·	Mother's Name <i>(First, Mid</i> ucy Butta	die, Maide	e, Maiden Surname)		
, Mar	1 and 2 shou of Health and item 27 Is m other traum		19a. Informant's Name/Relationship (Type Michael J. Yuck		d 31	Nailing Address (Street and Nu. 13 East Nor		nber, City KWay	or Town, State, Zip Baltim	ore,Md212	
more	Page 1 a nent of H ant: If ite ury or oth		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	ob. Place of D cemetery, t.Sta	isposition (Name of crematory or other place) nislaus Cem	Jul 1946 28, 201	- 1	Location - City or T ltimore	own, State, Maryland	
Balti	permit.   Departn Importa any Inju		21. Signature of Funeral Service Licensee		/	22. Name and Address of F	k Avenue	vski Ralt	Funera	1 Home, P.A	
			23a. Part 1. Enter the disease or complice shock, or heart failure. List only one				h as cardiac or respirator	y arrest,		Approximate Interval Between	
C	Pnysician/ ∤ Medical	17	Immediate Cause (Final disease or condition resulting in death)	MUCH	100	GAN 5 457	Pag 10			Onset and Death	
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	ted 1 Insit	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a cor	nsequence of):						
ه ا	certificate be executed inding physician and use as the burial-transit	edical Examiner	that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):						
Box 68760	n certificate ending phy r use as th		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pr			23d. Date of deli				
. B	ne deat y the att ched fo	by Physician/M	1 Yes 2 X No	4 Pregnant at time 9 Unknown	e of death	5 Other (specify)			Month	Day Year	
P.0	s that the gned by be deta	by P	Part II. Other significant conditions conf	ributing to death but no	ot resulting in t	he underlying cause given in F				the cause of death?	
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talF	cian: T ertifica ector, p		25. Was case referred to medical examiner?	74-1			Death (Check only one)	es 2 🕰	No. 1 Hes	2 11/10	
Ϋ́	Physic this c	<u>د</u>	1 ☐ Yes 2 No Ho  27. Manner of Death	spital: 1 Inpatient 28a, Date of Injury	2 ER/Outp		Nursing Home 5 F			fy)	
o uo	inding ath. r: After ie fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yea				oe now in	jury occurred		
Division of Vital Records,	al or Atte s after de il Directo ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp		, street, factory, office		n (Street : Town, Sta	and Number or Run ite)	al Route Number,	
-	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical Examine	ian: To the best of my kr: On the basis of examin	nowledge, de nation and/or in of my knowled	ath occured at the time, date anyestigation, in my opinion, dearge, death occurred at the time,	and place, and due to the th occurred at the time, da date and place, and due t	e cause(s) ate and pla o the caus	and manner as stated ace, and due to the cale(s) and manner as s	ted. ause(s) and manner stated stated.	
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<u> </u>			30. Name and address of person who con	PH V	(Item 23a) (Typ	ath occured at the time, date is westigation, in my opinion, dea ge, death occurred at the time,  29c. License numb  29c. License numb  29c. Print)  M. C.M. OX	eise do	SPI	TAL		
پ	Stat Registra		31. Date filed (Month, Day, Year) AUG 0 9 201	32 Agistrar's S	ignature.	parked					
MHD MH	/IH 17 Rev 7/20	09			ORIGIN						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G918 8/09 2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Medical Facility Name (if no institution or Location of Death 4c. County of Death Examiner eet and N/A If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year **Funeral** Months 1 M 2 🗆 F 0372971945 212-46-0929 Maryland do Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1√ Yes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 543 N. Fulton Ave. 21223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ 1 Yes 2 XNo Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 12th Grade College (1-4 or 5+) truck Driver Salvation Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ George Young Geneva Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geneva Colbert(sister) 8760 Mary Lane, Jessup, MD 20794 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Exremation 3 Removal from State on0 On-Site Crematory 08/02/11 Baltimore, 4 Donation 5 Other (Specify) Signature f Funeral Service Licensee Oseph H. Brown Jr. Funeral Home 140 N. Fulton Ave., Baltimore, I Josej 2140 MD 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pruse on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner riany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last the attending physician ned for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No page 2 should be detached g 🗌 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has 1 Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2  $\square$  No ျှ ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) injury Natural 5 Pending М 1 🗌 Yes 2 🗌 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature ar 29c. License number 0853 30. Name and address person who completed cause of death (Item 23a) (Type, Print) Hane 31. Date filed (Mor h, Day, Year) State 0 9 201 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #20a-c Per FH G918 8/16/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Susanne 20210 Medical 01 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death world west - men & 1405 5. Social Security Numbe 6. Sex 7. Age (In vrs. last birthday Year If Under 24 Hrs. 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign July 30 1 🗆 M 2 🗷 F Months Days Hours Min. Country) Maryland Director 216 48 0955 Yrs 1947 Usual Residence of Decedent f show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits rector 28a-f 1 ☐ Yes 2X No MD Baltimore Reisterstown ō 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 308 E Chatsworth Avenue 21136 U.S.A. hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 x No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Unemployed N/A event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ George Zue1ch permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic Keaney Helen M. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister 308 E Chatsworth Avenue Reisterstown, MD 21136 <u>Denise Zuelch</u> Law Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Dreider Ridge) Cemetery 20c Location - City or Town State Pikesville, MD 8/12/2011 Burial Excremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll 8/11/11 Cremation Ser Humpstead, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road 20 ELINE FUNERAL HOME Reisterstown, MD 21136 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Sent-a disease or condition Show Medical resulting in death) Due to (or as a consequence of) Examiner Cellul-+-3 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Den-ahanil nding physician and use as the burial-trar Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the the Unknown 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Respirates relunshould 24a. Was an . Were autopsy findings available prior to completion of cause of F. B n. 11 athas page 2 autopsy perform death? certificate 1 ☐ Yes 2 ☑ No Yes 2. No Division of Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tes 2 No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 Accident
3 Suicide
4 Homicide 2 🗌 No filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one) 29b. Signature and title of certifie. 29c. License number 29d. Date signed (Month, Day, Year) 4 2908 7 2011 AUguet 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 113 mo 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ 201 ABDELAZIZ SSEF Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GALTHERSBURG MONTGOMERY 9. Birthplace Country) 8. Date of Birth **Funeral** 1 M 2 - F **Director** 28a-f show 10d. Inside City Limits 10c. City, Town or Location must be notified at Director 1X Yes 2 ☐ No GAITHERSBURG 10e. Street and Number 10g. Citizen of What Country? ō Funeral 20878 or items 23a USA SULLNICK 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status the Medical Examiner Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 1 🗌 Yes 2 📉 No Specify: WHITE If Yes, Give Specify 3 ₩Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. College (1-4, or 5+) Elementary/Seconday (0-12) SUGAR MILL MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental Fishers is marked or မ ABDELAZ IZ HKMAI 19a. Informant's Name/Relationship (Type, Print) Sch - In Laky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau TERR. MARTINSBURG WV. 2544 KHODARY 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other FREDERICK. 4 Donation 5 Other (Specify) 22. Name and Address of Facility ADEN MUSLIM FUNERAL SER Signature of Funeral Service Licenses ST WOODBRIDGE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine burial-tran attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ned by the atten in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by e could Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N has this certificate 2 No 1 Yes completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 💢 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M cause of death (Item 23a) (Type, Print)

State Registrar

604 SOUTH FREDERICK AVE GAITHERSBURG 31. Date filed (Month, Day, Year) 2 7 2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pleas	se Type or Prin					•		gibie.				
		For State Registrar	State of Ma	-	Certifica			, ,	-	111	25348			
		Decedent's Name (First, Middle,	Last)		Cortino	ate or E	, catri	2. Date of Dea	Reg. No.		3. Time of Death			
Physicia Medio			UWENA	<u> </u>		LLA		Month 07	20 Day	2011	0910 M			
Examin	er	4al Facility Name (if not institution, s Anne Arundel M		er	4b. C	•	Location of Dea	5		nty of Death ne Ar				
Funeral Director		579-34-4006	6. Sex 7. Age	(In yrs. last birth	yrs. If Un Monti	hs Days	If Under 24 Hr Hours Mir		h (, Yea <i>r</i> ) 1927	9. Birth Cou	nplace (State or Foreign Intry) Virginia			
nd how at	'n	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits			
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with the 23a or ust be n	Funeral Director	10e. Street and Number 6391 Rowanberry	Drive		10f.	Zip Code 210	75		10g. Citizen o	of What Cou	intry?			
items	Fun	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was De	cedent of Hi	spanic Origin? ( n, Mexican, Pue	Specify Yes or No-		Race - Ameri				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	1 Never Married 2 Marrie 3 XWidowed 4 Divorced	ed 1 Yes 2 1 N If Yes, Give Year or Dates.	No		s 2 No	Specify:	rto Ricari, etc.)	Spec	Black, White,	White			
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nd 2 sho ealth an n 27 is i		19a. Informant's Name/Relationship Harold L. Padge	, , , ,		-			Rural Route Number Road, Pas			,			
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mit. Pa partme portan injung		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Faneral Service Lice		Trinit		Garde and Addres		/27/2011			-			
permi Depar Impo any ir once.		//en	<b>V</b> 7				,	Beall y. Bowie,	Funera MD 20	1 Home 715	e 			
		23a. Fart 1. Enter the disease, or implication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. I only one cause on each line.  Immediate Cause (Fin.)  Approximate Interval Between Onset and Death												
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Examiner	er	Sequentially list conditions,	b. —			H	TN				y en			
uted d ansit	cal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a	consequence o	f):						J			
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the deal by the at ached fo	hysic	1 Yes 2 No 9 Unknown	4 L Pregnant at 9 D Unknown	time of death	5 Other	(specify)				Month	Day Year			
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 L. Medical Ex	Physician: To the best of maminer: On the basis of exa	amination and/or	investigation,	in my opinio	n, death occurred	d at the time, date ar	nd place, and	due to the c	ause(s) and manner stated.			
To the within To the comple	Š	only one) 3 L. Certifying N 29b. Signature and title of certifier	Nurse Practioner: To the b	est of my knowle		courred at the 29c. License			cause(s) and 29 <b>d</b> Date sig					
63		Mul	# 21	NT W	1	D	2143	8	Juli	120	2011			
3		30. Name and address of person wi	a CWA	ath (Item 23a) (Ţ	ype, Print)	FEN	SE HW	n ANNI	Apocis	MD	21401			
Stat Registra		31. Date filed (Month 11 Yes) 5	2011 32. Rigistrar	's Signature	6-			1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25349 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0 9 30 M Physician/ Month AMES Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12203 Foxhill Lane Prince George's **Bowie** Social Security Number If Under 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 8, Date of Birth 1 M 2 D F Months Davs Hours Min. 03-23-1930 Director 267-36-1305 Florida 81 Usual Residence of Decedent er man "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Bowie TXTY Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12203 Foxhill Lane 20715 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or DatesKorean White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other traumatic according to the trauma Elementary/Seconday (0-12) College (1-4 or 5+) Civil Service 5+ U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Allen, Sr. Nollie Elizabeth Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia A. Allen/Spouse 12203 Foxhill Lane, Bowie, MD 20715 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Christ Episcopal Cem. 07/23/2011 Clinton, Maryland 21. Signature of Enneral Service 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23 P 11. Enter the disea e, or complications that aused shock, or heart failure. List only one cause in each line , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ seasi disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any less in cause. Enter Underlying Cause (Disease or iinjury Due to (or as a nonsequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been signal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 잍 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27, Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No the f Accident Investigation Suicide Could not be Swithin 24 hours after do
To the Funeral Directo
completed filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

WHIJA

31. Date filed (Mo

Box 68760

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25350 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $\mathtt{JULY}^{\mathtt{Month}}$  21, 2011 ANITA VIVIAN ANDERSON 12:55 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, 1 M 2 KF Months Days Hours Min. Director Pennsylvania 190-26-1558 76 Feb. Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Howard Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3283 Jones Road 21797 United States 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 7; Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Research Nurse Medical Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gerald Johnston Lorna Freda Lawhead Fleurence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Healt Important: If item 2 any injury or other 1 Jones Road, Woodbine, MD 21797 <u>Jack K. Anderson/Husband</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 7/27/2011 Brookeville, MD 21. Signatury of Fur a al Service Linnsee 22. Name and Address of Facility Muriel H. Barber Funeral Home 00470 Laytonsville. P.O. Box 5038, MD 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ acul Vc' disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of Completed by Physician/Medical Sam. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No ျု Other: 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5  $\square$  Pending 1 Yes 2 No Investigation 6 Could not be s after death 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Revical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Practical Examiner: To the best of my knowledge. Seet occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signatur チしひしし 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10301 Georgia Ave., Silver Spring, MD 20902 Ahmed Y. Heshmat, M.D. 31. Date filed (Month) State egistrar's Signature 5 Ensua Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 25351 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 16, 2019 12:37 AM Butler Mary Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. Cheverly Prince George's Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Hours Min 217-26-0794 84 MD **Director** Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director Hyattsville 1 X Yes 2 No MD P.G. 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20785 U.S. 5705 Beecher Street death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married ☐ Yes 2 🔀 No after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Black "natural", Specify. 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired)  $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12th \end{array}$ College (1-4 or 5+) Domestic Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ Butler Mary В. Butler Joseph other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 si Department of Health ar Important: If item 27 is any injury or other 5705 Beecher St. / Hyattsville, MD 20785 Arlene B. Gaskins/Daughter 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗵 Burial 2 🗆 Cremation 3 🗔 Removal from State Glenwood Cemetery 17/23/2011 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The House of Williams Funeral 21. Signatur of Funeral Service Licensee & Crem. Svcs/814 Upshur St, NW/Wash, DC 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final SE Onset and Death Ph sician/ disease or condition Medical resulting in death) **Examiner** DEMENTHA Sequentially list conditions Due to (or as a consequence of if any, leading to immediate Exami that the death certificate be executed Cause (Disease or linjury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnation 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Pregnant at time of death Month Year Unknown 9 Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? 2 No 1 Yes Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🚰 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 2 Accident
3 Suice 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical 1 decritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

CR 4

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUKEN- Audella N. S. 3001 Hosp Hal DQ. Cheverly Md

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUL 2 7 2011 August M. Sauce

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			For State Registrar		State of Ma	arylan		artment of l		•	giene Reg. N	2011	25352	)
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, -	Medic Examin	al	Opal Dorot  4a. Facility Name (if not ins		street and number)			4b. City, Town, o	or Location of De		2,	2011 Year	9:20 aM	_
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	Funeral Director		5. Social Security Number  578-50-7002  Usual Residence of Deceding		ex □ M 2 🖾 F	(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days			th y, Year • IS	9. Bir Co	rthplace (State or Foreign ountry) Jamaica	_
	ryland -f show ied at	ctor		ounty		10c. City	, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	he Mau or 28a e notifi	Director	MD 10e. Street and Number	lontgo	mery	Si	llver	Spring 10f. Zip Code			10g. C	itizen of What C		-
	s 23a o	Funeral	11500 Char	lton I	rive	_		20902				USA		
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Fur	11. Marital Status  1 Never Married 2  3 Widowed 4 Di	_	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒☐ If Yes, Give Year or Dates.			Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 🔀 No	an, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		14. Race - Ame Black, Whit Specify: Bla	te, etc.	
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ನಿ() . Box 687	ne death or the atter ched for u	To Be Completed by Physician/Me	in the past 12 months 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		1			Ectopic pregnan Other (specify)	icy			Month	Day Year	
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フースみ・るのハ し Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		4  Homicide	determined	building, etc	. (Specify)				City or Tov	vn, State	e)	ural Route Number,	
	n 24 ho n 24 ho ne Fune bleted fi	Medical	(Check 2 Me	dical Exami	sician: To the best of r iner: On the basis of ex se Practioner: To the b	amination	and/or inves	tigation, in my opini	ion, death occurre	d at the time, date a	and plac	e, and due to the	cause(s) and manner state	ed.
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200	<b>み</b>		30. Name and address of p Hasitha Wi	alerani					getown H	Road, Bet	hes	da, MD 2	20814	
	Stat Registra	e ar	31. Date filed (Month Day	272	32. Fegistra	r's Signat	ure	arkel						
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						0	RIGINA							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25353 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month . Norman Edward BENNER Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hagerstown 302 S. Locust Street Washington If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Ye Oct. 15, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 🕱 M 2 🗆 F 69 Director 215-34-4069 Oct. 1941 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Maryland Washington Hagerstown 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 302 S. Locust Street 21740 death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and Mental Hygiene. þ 1 Never Married 2 X Married 1 ☐ Yes 2 k No
If Yes, Give
Year or Dates. 1961-65 Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify. Specify: white Completed 3 Widowed 4 Divorced or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 mechanic trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norman Edward Benner Sr. Mildred Suffecool 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other trau Delinda Benner - wife 302 S. Locust St., Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛛 Burial 2 🗌 Cremation 3 🗌 Removal from State Rose Hill Cemetery 7/29/11 4 Donation 5 Other (Specify) Hagerstown, Maryland Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ear Physician/ disease or condition Medical resulting in death) Due to ur as a consequence of): Examiner Se wentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown P.O. signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Aeriai Division of Vital Records, 1 Yes 2 No 3 No Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? al Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: hours after death.

neral Director: After this or filled in by the funeral dire 2 💢 No 1 Tes 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Cartifying Nursa Fractioner: To the best of my knowledg 29b. Signatu 29d. Date signed (Month, Day, Year)

State

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Sherto MD

rson who completed cause of death (Item 23a) (Type, Print)
16, MD 11110 Mcdlcal Campus Rd #223 Hagestown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ JUL 20, 2011 Amador Garcia Borrayo Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16617 S. Westland Dr. Gaithersburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 ★ M 2 □ F APR 30. Yrs. 1915 Navarit, Mexico **Director** 96 217-53-0347 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 16617 S. Westland Dr. 20877 Mexico Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. 1 Never Married 2 Married 2 3 No ☐ Yes Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 → Yes 2 □ No Specify: Mexican 3 🔀 Widowed 4 🗆 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ranch 0 Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental F 7 is marked of ည <u>Elias Garcia</u> Lina Borrayo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod. 34139 Judy Lane, Catherdral City, CA 9223 1 and 2 s of Health item 27 Angelina Rivera/Daughter 20a. Method of Disposition 20c. Location - City or Town, State La Varas, Nayarit 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place)
Sendero de Luz y
Esperanza 1 🛣 Burial 2 🗋 Cremation 3 🛣 Removal from State 4 Donation 5 Other (Specify) Mexico 7/29/2011 . Signature of Funeral Service Licens Thibadeau Mortuary Service, p.a.
7 Park Ave., Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only N e cause on each line. Immediate Cause (Final Physician/ disease or condition Lung Mass of Unclear Etiology Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed? Yes 2 % No 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 🔁 Residence 6 Nother (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 🖈 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

25354

1:45 P M

1 Yes 2 No

92234

Approximate Interval Between

Day

29d. Date signed (Month, Day, Year)

Year

Onset and Death

D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman, 1355 Piccard Dr., Rockville, MD 20850 MD State

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of cert

29c. License numbe

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 7/22/201 FRED F. BLANKEN 0057A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Months Days Hours Min. Month 1 733 1 **X** M 2 □ F **77** 577-44-7354 WASHINGTON, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits SILVER SPRING MONTGOMERY 1X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? SOUTH LEISURE WORLD BLVD. 531B 20906 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 X No Black, White, etc 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **BUSINESS BROKER** COMMERCIAL BUSINESS BROKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, HELEN FURR SAM BLANKEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAURA SWERDLIN-DAUGHTER 18125 BILNEY DR. OLNEY, MD. 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GARDENS 7/24/2011 OLNEY, MD. 21. Signature of Funeral Service Licensee . Name and Address of Facility DANZANSKY GOLDBERG MEMORIAL CHAPEL MO0910 1170 ROCKVILLE PIKE ROCKVILLE, MD. 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CARDIO PULMONARY ARREST disease or condition resulting in death) Due to (or as a consequence of) ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury

Physician/ Medical **Examiner** 

Physician/

Medical

State

2901

10a Si **MD** •

Director

Funeral

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Completed

Be

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**Examiner** 

**Funeral** 

**Director** 

28a-f shov

er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at

and Mental Hygiene. is marked other than

permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau

other traumatic event,

hours after death

Baltimore, Maryland 21215-0036

Examine Physician/Medical Be Completed by Certificate: To funeral within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

that initiated events										
resulting in death) Last	Due to (or as a consequence of):									
	d									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1   Live Birth 2   Fetal death 3   Ectopic pregnancy  4   Pregnant at time of death 5   Other (specify)  9   Unknown	23d. Date of delivery Month Day Year								
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown								
		24a. Was an autopsy performed? 1. □ Yes 2 ▼ No 24b. Were autopsy findings available prior to completion of cause of death? 1. □ Yes 2 ▼ No								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1  Yes 2 No	Hospital:  1 XInpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigatio	( <i>Month, Day, Year)</i> injury work? n M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)								
	sician: To the best of my knowledge, death occured at the time, date and place, and c iner: On the basis of examination and/or investigation, in my opinion, death occurred at the									

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D63579

State Registrar

Medical

31. Date filed (Month, Day, Year) JUL 2 5 2011

3 🗆

29b. Signature and title

park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIA TAYAĞ

29d. Date signed (Month, Day, Year)

7//22/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Day JulyPhysician/ 22 2011  $\mathbf{a}^{\mathsf{M}}$ Virginia Ruth Bennett 9:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rockville Nursing Home Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day Days Hours Months 1 M 2X F 90 233-42-3548 **Director** Aug. Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 XYes 2 No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 303 Adclare Road 20850 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, <u>ک</u> 1 Never Married 2 Married Maryland 21215-0036 72 hours after White 1 ☐ Yes 2 ☐ No Specify. Specify: marked other than "natural", 3 X Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) and Mental Hygiene Business Manager Dry Cleaning & Insurance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٩ Donley Bencen Hostutler Mary Elizabeth Ballinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .0 1 and 2 s of Health a item 27 i Randall Drew Bennett/Son 1912 Merrifields Drive, Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 

Burial 2 

Cremation 3 

Removal from State cemetery, crematory or other place) Ridge Memorial Blue 4 Donation 5 Nother (Specify) entombment Beckley, West Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 00 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Hypertensive Heart Disease Medical resulting in death) Due to (or as a consequence of) **Examiner** Pulmonary Embolism Sequentially list conditions Examine cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Atrial Fibrillation Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Dementia Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death ed by the detached 9 Unknown 9 Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Septicemia 1 Yes 2 No 3 Probably 4 TUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2X No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 K Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. within 24 hours after death.

To the Funeral Director: A

Completed filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medica 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) الْ UMUN D47330 July 22, 2011 YWOUNGS Name and address of person who completed cause of death (Item 23a) (Type, Print) #207
Chomas Joseph, MD 50 W. Edmonston Drive, Rockville, MD 20852 Thomas Joseph, MD 31. Date filed (Month, Day, Year)

JUL 25 2011 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 25357 Certificate of Death Decedent's Name (First, Middle, Last)
Derek C. Crosby 2 Date of Death 3. Time of Death Month / Physician/ 9:37AM 201 Medical 4a. Facility Name (if not institution, give street and number)
Doctors Community Hospital 4c. County of Death 4b. City, Town, or Location of Death **Examiner** P.G. Lanham 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 578 – 78 – 9061 **Funeral** 1 🗚 1 □ F Hours NOV. 7, 1963 Wash., D.C. **Director** Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. P.G. Lanham Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8505 Magnolia Drive Funeral 20706 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc.
Black  $(\mathcal{K} \bigcirc \mathcal{K} \bigcirc \mathcal{K} ) e \mathcal{L}$  Baltimore, Maryland 21215-0036 þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates. 1983-85 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Fed. Gov. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Security Spec Technology I.R.S. Be 17. Father's Name (First, Middle, Last)
Harold L. Crosby 18. Mother's Name (First, Middle, Maiden Surname) Alene Tweedy 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kheli T. Crosby 8505 Magnolia Drive Lanhan, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State Washington, D.C. Glenwood Cemetery July29,11 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Robinson Funeral Home 1313 Wash., 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pulmonar Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or anying Cause (Disease or iinjury Due to (or as a consequence of): Exami that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death the t ed by the signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hypercoagulopathy 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examina? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Mem 7/21/11

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2011

JUL 2

Good

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma		Certificate				glene2 () Reg. No.		25358
:	hysicia	n/	1. Decedent's Name (First, Middle, La	ast)					2. Date of De Month 07	- 41-	- Year	3. Time of Death
	Medic Examin	al	Raymond W. Carr  4a. Facility Name (if not institution, given	e street and number)		4b Ciby To	wn, or Location	on of Doath	07			9:35 A M
	Examin	er	638 Bell Manor R			Conov		on or Death		4c. County of Death Cecil		
	uneral		Social Security Number 6.		(In yrs. last birtho	(ay) If Under 1		der 24 Hrs.	8. Date of Birl	h Vear	9. Birth	place (State or Foreign
	irector		214-26-5879 Usual Residence of Decedent	TEM V Z L F	79 Y	s.			9/9/19	31	Count	MD
land	show d at	tor	10a. State 10b. County		10c. City, Town o	r Location					1	0d. Inside City Limits
Mary	28a-f otifie	irec	MD Cecil		Conowir	igo						1 🗌 Yes 2 🙀 No
ith the	3a or t be r	ral 🗅	10e. Street and Number			10f. Zip C				10g. Citizen o	f What Cour	ntry?
eath w	r mus	Funeral Director	638 Bell Manor R	12. Was Decedent Ev	ver in U.S.	2191 13. Was Deceden If Yes, specify		Origin? (Spe	cify Yes or No-	USA 14. Ra	ace - Americ	an Indian.
affer de	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Ex-miner must be notified at once.	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 N If Yes, Give	10	If Yes, specify			Rican, etc.)	Bl	ack, White,	etc.
<b>Z 13-0030</b> in 72 hours after	atura ical Ex	Completed	3 🙀 Widowed 4 □ Divorced  15. Decedent's	Year or Dates.	16a. D					Specification 16b. Kind of	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ite
<b>5. 13</b>	Med "	dwo	(Specify only highest g	rade completed)  College (1-4 or 5-	-) /ii	ecedent's Usual C Give kind of work of fe. DO NOT use re	etired)					, i
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Vitaria Id be filed Mental Hy	ked o	To E	Roy Cox						e (First, Middle, ae Carr		ne)	
Mary 2 should	is mai sumat		19a. Informant's Name/Relationship	Type, Print)	19b. N	/ailing Address (S					State, Zip 0	Code)
and 2 s	nm 27 her tra		Dan Carr - Son		T	Harrisv		Road,	Colora,			
Dalumore, bermit. Page 1 and Department of Hes	t: If ite / or ot		20a. Method of Disposition  1  Burial 2  Cremation 3	Removal from State	cemetery,	risposition (Name crematory or othe	er place)		27/2011	20c. Location	•	
altır mit. Pg	oortan / injun	- 8	4 ☐ Donation 5 ☐ Other (Spec 21. Signature — Peral Service Licer		R.T.Foa	rd Fuenr			T.Foard	Rising Funera	Sun,	mD ne, P.A.
per D	any ir	Į į	+ trace.	My take					ising S			
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Exa	miner			. Cov	Consequence on	·1 (2	rter	V	Pisa	CLER		71000
ъ	Ħ	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury									
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s that	signed by the s	ρ	Part II. Other significant conditions	contributing to death bu	t not resulting in t	he underlying cau	use given in Pa	art I.				e cause of death?
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ian:	ertifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of D	eath (Check	1 Yes	2 M No	1 L Yes	2 E No
hysic	this ce	은	1 Yes 2 No		nt 2 ER/Outp		_		me 5 Design			)
ding I	: After	Certificate:	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day,			. Injury at work? 1 ☐ Yes 2		Rd. Describe h	ow injury occur	red	
r Attenter deat	rector	ertifi	3 Suicide 6 Could not 4 Homicide determined	be 290 Place of Injur		, street, factory, o		_	28f. Location (S		ber or Rural	Route Number,
pital o	eral Di											
To the Hospital or Attending Physician: The law requires that the death certiful Athorns after death.	To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	(Check 2 \( \sum \) Medical Exan	ysician: To the best of m niner: On the basis of exa rse Practioner: To the b	amination and/or it	vestigation, in my	opinion, death	occurred at	the time, date a	nd place, and d	ue to the cau	use(s) and manner stated.
To th	To th		29b. Signature and title of certifier	11.		29c. Li	icense numbe	<u> </u>		29d. Date sign		
	,		fore //				4716	5		July	26,	2011
	le		30. Name and address of person who	Mix	12. 14.00	pe, Print)	EI	ton	18.1	0 2/9	>/	
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	41	, - 1		U J			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 07 2011 10:42 Joseph Roland Cumberland, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 1 X M 2 -8. Date of Birth **Funeral** Hours 0576871920 Director 579-18-8502 91 Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Prince Georges Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3811 Sunflower Circle 20721 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian Armed Forces?
1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Optician 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Roland Cumberland, Sr. Helena Pulski injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trau 3811 Sunflower Circle, Mitchellville, MD 20721 Shirley Cumberland / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Lakemont Memorial Gardens 07/27/2011 1 X Burial 2 Cremation 3 Removal from State Davidsonville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Kary 8200 Jennifer Lane, Owings, MD 20736 &off Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Ind Death Immediate Cause (Final Ph\_sician/ 00 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Examir burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12-months? Pregnant at time of death Yes 2 No been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death. Funeral Director: After this certificate has autopsy death? 1 Yes Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 ျပ 1 🗀 Yes ER/Outpatient 3 DOA 1 Inpatient 2 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Datural Accident injury 5 Pending 1 Yes 2 No Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On th basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practi To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29d. Date signed (Month, Day, Year) 07/21/2011

Registrar

JRW

30. Name and address of person who o

e Uer

ompleted cause of death (Item 23a) (Type, Prin

r's Signature

		1 - State of Ma	-	epartment of H Certificate of I		_	giene Reg. N2	011	25360	
Physicia		1. Decedent's Name (First, Middle, Last)  JERRY WAYNE	CECIL			2. Date of De Month JULY	Day	2011	3. Time of Death  2:05 P <sup>M</sup>	
/Medica Examina Funeral Director	- 1	4a. Facility Name (If not institution, give street and number) 6775 Old Solomons Island Ro 5. Social Security Number 230-60-6050  67. Age	(In yrs. last birt	Friends		8. Date of Bir (Month, Da 01/09/	4c. C	ounty of Dea	th	
pri reprografishings	tor	Usual Residence of Decedent  10a. State 10b. County  MD Anne Arunde1	10c. City, Town	riendship					10d. Inside City Limits 1 □Yes 2 🗓 No	
th with the 23a or 28a ist be not	Funeral Director	10e. Street and Number 6775 Old Solomons Island Ro		10f. Zip Code 2075	8			en of What Co		
urs a	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent E Armed Forces? 1 Yes 2 N F Yes, Give Year or Dates:	<b>VIETNAM</b>	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (S nn, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		I. Race - Ame Black, Whit Specify: W.		
d within 72 ho giene. rr than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-1)	-)	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired eneral Cont	during most of wor l)	king		of Business	•	
Mental Hyg arked othe atic event,	17. Father's Name (First, Middle, Last)  Ollen B. Cecil  Nell Marie Gilbert						'urname)			
and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (Type. Print)  Jerry W. Cecil, Jr. / Son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 3930 Dalrymple Road, Chesapeake Beach, MD 20732								
permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiener Important: If item 27 is marked other than "n any Injury or other traumatic event, the Medione.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	1.	Disposition (Name of y, crematory or other place)  Veteran's Cen	n. 07/2	Date 8/2011	Che1	ation - City or tenham	, MD	
permit Depart Import any In		21. Signature of Funeral Service Licensee		22. Name and Addres					5	
Physician /Medical Examiner	Examiner	Sequentially list conditions b.	Ð.	of):	g, such as cardiad	c or respiratory a	rrest,		Approximate Interval Between Onset and Death	
cate be physicia the bur	dical	resulting in death) Last  Due to (or as a	consequence of	of):						
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome public to the pregnant at the p	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _			23	3d. Date of de Month	elivery Day Year	
es the igne	þ	Part II. Other significant conditions contributing to death bu CHRONIC OBSTRUCTIVE PULMONA	_		en in Part I.		tobacco us Yes 2□		to the cause of death?  Probably 4 Lunknown	
	Completed	OF Warrant of wide well-all					psy ormed? 2 <b>X</b> No	prior to death?	utopsy findings available completion of cause of s 2 \sumbox No	
Physician; this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1 ☐ Inpatier	nt 2□EB/Out	tpatient 3 DOA Oth	26. Place of Dea er: 4 ☐ Nursing H			Other (Se	acity)	
Attending or death.	Certification: T	27. Manner of Death  1  Natural 2  Accident 3  Suicide 4  Homicide  28a. Date of Injur (Month, Day) investigation 5  Could not be determined  28e. Place of injur building, etc	y <i>Year)</i> 28b. T	ime of 28c. Injur		28d. Describe	how injury	occurred	Rural Route Number,	
To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	examination an							
To the Within Committee Co	Ž	29b. Signature and title of certifier  **EAUGLACK: Her	5	29c. Licens	e number 33255			25, 20	oth, Day, Year)	
drw 8		30. Name and address of person who completed cause of de KAREN ANN BLACKSTONE, M.D.,	VAMC,	50 IRVING ST		, WASHIN	igton,	DC 204	22/688	
Stat Registra		31. Date filed (Month, Day, Year) 32. Registra	Signature	B. Sparke						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 25361 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 215pm nard 110 2011 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** 4c. County of Death NMS Healthc Inder Vear | If Under 24 Hrs. ast 7. Age (In vrs. last hirthday 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 1 X M 2 - F Hours Min Oct. 30,1944 221-28-9324 Delaware Director 66 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director Maryland Washington County Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 21742 U.S.A. 14014 Marsh Pike death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ð 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry Je filed with.. r⁴al Hygiene, 'Ser than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Veteran Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Unknown Ashby Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 15884 North Mountain Rd. Broadway, VA 22815 Ray Allen Cole-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 7-29-2011 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Lice 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ onar disease or condition Medical resulting in death) Due to (or as a consequent of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? jo Month Day Year ed by the detached Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Knsion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed is Mellitus 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autopsy performed? Yes 2 No death? certificate 2 🗆 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other ၉ 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completed filled in by the funera 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie K118578

Registrar
DHMH 17 Rev 7/2009

State

MD

Hagers town

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar 25362 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $\mathbf{July}^{\mathsf{Month}}$ 25 Day 2011 1:06 A M Warren Cline, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 26 E. Salisbury St. Williamsport Washington Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 1 🛛 M 2 🗆 F Months Days Hours Min Washington, Director 578-34-3094 82 June D.C Usual Residence of Decedent 28a-f show 10a State 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26 East Salisbury St. 21795 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 

Yes 2 □ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: Completed 3 X Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Farm Equipment Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Dealership 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Tracey Cline Ella Wilhide 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas H. Cline/Son 305 N. Mulberry St., Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 7/26/2011 4 Donation 5 Other (Specify) Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 5. Mull 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or compiler ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hronic Obstructive Pulmenony Distersanset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed sician and burial-tran Due to (or as a consequence of): nding physician use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕻 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed Yes 2 No page certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Tyes 2 No Other: ြုင 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a, Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1. Natural injury 5 Pendina 2 Accident
3 Suicide Investigation Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifler Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760 Records, P.O. Hospital or Attending Physician: Division of Vital

Registrar

TIN-

State

29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ND

sccarelli

Lendle

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Read Williamsport

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylan		artment of F tificate of L	lealth and I Death		giene Reg. N20		25363
	Physicia		Decedent's Name (First, Middle, I	Last) Rhonda	Моцол	Cohen			2. Date of Dea Month July	ath	011	3. Time of Death 12:45р м
	Medic Examin		4a. Facility Name (if not institution, g			Content	4b. City, Town, or	Location of Death			y of Death	<del></del>
				Hospital			В	ethesda			Monte	gomery
Ŋ	Funeral Director		5. Social Security Number 098-38-2301	5. Sex 1 ☐ M 2 🗶 F	. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 02/14		9. Birth Cour	place (State or Foreign ntry) New York
	ld now	Ļ	Usual Residence of Decedent  10a. State 10b. County		10c City	y, Town or Loc	eation					10d. Inside City Limits
	anylar sa-f sl	ectc	Maryland Mont	gomery		,,		Kensingto	วท			1 ☐ Yes 2 🔃 No
	the M	Dir	10e. Street and Number	joinery			10f. Zip Code	. Constant		10g. Citizen of	What Cou	ntry?
	h with 1s 23e nust b	Funeral Director	3611 Duj	oont Avenu	ie			20895			u.s	.A.
36	ould be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marke other, the Medical Examiner must be notified at	Completed by Fu	Marital Status     Never Married 2  Marrie     Widowed 4 □ Divorced	If Yes, Give	es? 2 🛣 No	l II	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - Americack, White,	
ğ	hours natura lical E	lete	15. Decedent	Year or Date s Education	es.		ent's Usual Occup			16b. Kind of 8		
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and	be file lental l- rked o ic eve	To E	17. Father's Name (First, Middle, La:  Ma.	nny Meyer				18. Mother's Nam		Maiden Surnan L Schwo		
Maryland 21215-0036	should be and Mer is marke aumatic	100	19a. Informant's Name/Relationship			19b. Mailin	g Address (Street a	and Number or Rur	al Route Numbe	r, City or Town,	State, Zip	Code)
	473	7.0	Stuart Cohen ·	- Spouse		3611	Dupont	Avenue, 1	Kensingt	ton, Ma	rylan	d 20895
ore	= 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1		20a. Method of Disposition 1 Ⅺ Burial 2 ☐ Cremation 3	Removal from S	tote C	emetery, cren	sition (Name of natory or other plac	e)	Date	20c. Location		
Baltımore,	permit. Page 1 Department of Important: If it any injury or o	3	4 Donation 5 Other (\$10	ecify)	Jud			rdns 07/2				aryland Home, Inc.
Ва	permit. Departr Importa any inji	10	21. Signature of Funeral Servic (Lice	grie Ul	10709							ng, MD 20904
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that car y one cause on each	used t <b>he</b> death i line.	h. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arr	rest,		Approximate Interval Between
ared.	Physician/ Medical	ñ	Immediate Cause (Final disease or condition resulting in death)				y Cancer	Stage II	V			Onset and Death
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Box 68	tth cer ittendi or use	Physician/M	23b. Was decedent pregnant in the past 12 months?		rth 2 🗌 Feta	ıl death 3 🗌	Ectopic pregnanc	э y			ate of deliv	very Day Year
ž	he dea y the a ched t	nysic	1 Pes 2 No 9 Unknown	9 ☐ Unknov	unt at time of c wn	ieain 5 ∟	Other (specify)					
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5	hysic his ce Il direc	2	examiner? 1  Yes 2  No	Hospital:	patient 2 🗌		t 3 🗆 DOA Othe	er: 4 🗌 Nursing H	ome 5 Resid	lence 6 🗆 Ot	her <i>(Specif</i>	y)
סר	ling P		27. Manner of Death 1    Natural 5 □ Pending		injury Day, Year)	28b. Time of injury	28c. Injury work	?	28d. Describe h	ow injury occur	red	
SIOI	Attenc r death ctor: y y the	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	ot be	f Injury - At ho	me, farm, stre	M 1 🗆	Yes 2 □ No	28f. Location /S	treet and Num	ber or Rure	V Route Number,
DIVISION OF	ital or / Irs after al Dire led in b		4  Homicide determin		, etc. (Specify,				City or Tow			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and  To the Funeral Director: After this certificate has been signed by the attending physician and  To applicate the funeral director, page 2 should be detached for use as the burial transit	Medical	(Check 2 Medical Exa	Physician: To the bes aminer: On the basis lurse Practioner: To	of examination	and/or invest	igation, in my opinic	on, death occurred a	at the time, date a	nd place, and d	ue to the ca	ause(s) and manner stated.
_	Vithi To th	_	29b. Signature and title of certifier	III C			29c. License			29d. Date sign		
	7		1		_			D0070027		Jul	.y 22,	2011
-			30. Name and address of person wh Haizia Amsler,					d. Rotho.	sda Mar	uland	20814	
	Stat	е	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signat	ure	A P	a, cone	2 0000 11100	-9.00100		
	Registra		JUL 25 20	32. Reg	w B.	MON	1					

11-05446 Sandra A. Cruz Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sandra A.	Oluz		1- For State Registrar	tate of Maryla		rtificate o		nd iviental f		2011	25364
Pr Medical E	nysici Exam		Decedent's Name (First, Midd     Sandra		Flores	d€	Cruz		2. Date of Deat Month July 20, 20	Day Year	3. Time of Death 2321 hrs
			4a. Facility Name (if not institution	_			4b. City, Town, o	or Location of Dea		4c. County of Death	
Fu	neral		Bowie Health Center  5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	Bowie  If Under 1 Ye	ar If Under 24H	rs. 8. Date of Birt	h/MM/DD/YYYY) 9 Birl	holace (State or
	ector		213-63-3148	1 M 2 X F		39 Yr	Months Da	ys Hours Mi	Sept.	10, 1971 Foreig	n F1 untrySalvador
	any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	ition				10d. Inside City Limits
and	E .	6	Md. Princ	e Georges	Boy	wie					1 X Yes 2 No
e Maryl	or 28a-f sho	Director	10e. Street and Number 16016 Alderwo	nod Lane			10f. Zip Code 207	16	10	og. Citizen of What Cour E1 Salvado	-
e, MD 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland Health and Marvel Huminana	ns 23a be notif	eral D	11. Marital Status	12. Was Deca	edent Ever in U.		as Decedent of H	ispanic Origin? ( \$	Specify Yes or No-	14. Race - Ameri	
er death	or iter	Funeral	1 Never Married 2 X M 3 Widowed 4 Div	larried Armed Fo 1 Yes vorced If Yes, Give Year	2 X No			an, Mexican, Puerloo o s <i>pecify:</i> Sa.1		White, etc.  Specify: While	+-
ours aft	atural"	d by	15. Decedent's Education (Spe	or Dates:		16a. Decede	nt's Usual Occup	ation (Give kind of	work done	16b. Kind of Business/l	
36 in 72 h	han "n dical E	Completed	Elementary/Secondary (0-12)	College (1-	4 or 5+)		memaker	e. DO NOT use re	etired)	Self-Emplo	yed
21215-0036 vuld be filed within 7	d other than '		17. Father's Name (First, Middle						ne (First, Middle, M	,	<u>-</u>
2121 ald be fi	narked event,	To Be	Teodoro Fe:	rrufino		19b. Mailin	a Address (Stre	Rosali		es ber, City or Town, State,	Zin Code)
MD:	a 27 is r	_	Adan Cruz	(Husb <b>an</b>		1601	6 Alderw	ood Lane		ie, Marylar	d 20716
- vs 4	: # º I		20a. Method of Disposition  1  Surial 2 Cremation	n 3 Removal fro	m Ctata C	rematory or of	sition (Name of ce ther place)		Date / 25 / 2011	20c. Location - City or Annapolis,	
Baltimore, permit, Pages 1 a	Important: injury or oth	1	4 Donation 5 Other S		1 1111	22.1	Name and Addres	ss of Facility		•	Haryland
	_	//	23a. Part I. Enter the disease, or	any		₩.	H. B <b>a</b> co 3447 14t	n Funera b Street	1 Home,	Inc. Washington	D.C. 200
	dical		failure. List only one cause	on each line.				, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
≛xam	iner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a			case				,
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of	):					
Ω	- 3	ledical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of	):					1
xecuted	ysician and burial - transit	Sal	UNPENDED	dAMENDED		_				· · · · · · · · · · · · · · · · · · ·	
<b>60,</b> ate be e	ohysicia ne burial		IF FEMALE:	23c. If yes, o	utcome of pregn	nancy			-	23d. Date of delivery	
certific	e attending phy for use as the	cian/	23b. Was decedent pregnant in the past 12 months?	1 Live bir		2 Te	etal death 3	Ectopic pregn	ancy		ay Year
Box ne death	the atte	Physician/N	1 Yes 2 No 9 V Uni	a outside							
Records, P.O. Box 68760, The law requires that the death certificate be executed	signed by I be detach	ā	Part II. Other significant condit	ions contributing to	death but not re	sulting in the i	underlying cause	given in Part I.		pacco use contribute to t 2 ✓ No 3 ☐ Prob	
<b>rds,</b> v requir	s been s	ompleted							24a. Was ar autops		opsy findings available ompletion of cause of
<b>of Vital Records, 18 Physician:</b> The law requir	icate ha page 2	Com							perform 1 Yes 2	ned? death?	2 No
/ital	his certificate director, page	æ	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	74	patient 2 🗸 I	ER/Outpatient		of Death (Check		Residence 6 Other:	
of \	After th	7: To	27. Manner of Death	28a. Date o		28b. Time of I	njury 28c. Inju	ury at Work?		ow injury occurred	
Division tal or Attendii rs after death.	ector: by the 1	catic	2 Accident Inves	stigation 28e Place	of Injury - At ho	me farm stree	1et, factory, office I	Yes 2 No	28f Location (St	reet and Number or Rur	al Route Number City
Div pital or	filled in by	Certification	4 Homicide deter	d not be mined (Specify)			.,,	ounding, oto.	or Town, Sta		a. reado (rambol, oxy
Division of Vital   lo the Hospital or Attending Physician: rithin 24 hours after death.	To the Fun completely	Medical (	(0)10011011)	miner:On the basis of	examination an					(s) and manner as state	
3	E LOS	Me	29b. Signature and title of certifie	and manner sta	ated.		29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)
	2		N-MU				O.C.	M.E.		July 21, 2011	
			<ol> <li>Name and address of person Donna M. Vincenti, MI</li> </ol>		edical Exam	iner 900		e Street, Baltir	more, MD 212	23	
R	St egist	_	31. Date filed (Month, Day, Year)	0044   A	istrar's Signatu	· par	red .				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	aryıan	_		te of D		лена пу	Reg. N	2111	25365
	Physicia Medic		1. Decedent's Name (First, Middle, La	<sub>st)</sub> 1sie Virgi	nia	Dalton				2. Date of De Month August		1 2011	3. Time of Death
	Examir		4a. Facility Name (if not institution, give 1520 East Old Ph	street and number)			4b. Cit	y, Town, or Elktor	Location of Death			1c. County of Dea	th
	Funeral Director		5. Social Security Number 6. S 229-36-9197	ex 7. Age		ast birthday) Yrs.		ler 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da JAN 29		9. Bir	thplace (State or Foreign untry) irginia
	th with the Maryland ms 23a or 28a-f show must be notified at	ctor	Usual Residence of Decedent  10a. State 10b. County			y, Town or Lo	cation						10d. Inside City Limits
	ne Mar or 28a	Funeral Director	Maryland Cecil  10e. Street and Number		E1	lkton	10f. Z	Zip Code			10a (	Citizen of What Co	1 Yes 2 X No
	with the s 23a oust be	eral	1520 East Old Ph	iladelphia	Roa	d		21921				United S	
336	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	ᅙ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ▼ If Yes, Give Year or Dates.	ver in U.S	3. 13. V		edent of His ecify Cubar 2 🙀 No	spanic Origin? (Sp n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		14. Race - Ame Black, Whit	erican Indian,
2-0	2 hours aft "natural", edical Exa	Completed	15. Decedent's E (Specify only highest gi	ducation		16a. Deced			ation uring most of wor	kina	16b.	Kind of Business	
2121	within 7; giene. er than , the Me	Com	Elementary/Seconday (0-12)	College (1-4 or 5	+)	Ìife. D	O NOT u	se retired)	operato	_	Ru	bber Man	ufacturing
Maryland 21215-0036	1 and 2 should be filed within 72 hours after dea f Health and Mental Hygiene. item 27 is marked other than "natural", or ite other traumatic event, the Medical Examiner.	To Be	17. Father's Name (First, Middle, Last) Charles James Ma	xwell					18. Mother's Nar		•		
Mary	2 should th and N 17 is ma trauma		19a. Informant's Name/Relationship (				_					or Town, State, Zi	
	of Health of Health of Fitem 27 i		20a. Method of Disposition		20b. P	lace of Dispo	sition (N	ame of	1	Date		Location - City or	
Baltimore,	permit. Page 1 Department of Important: If i any Injury or o		1 X Burial 2 Cremation 3 C 4 Donation 5 Other (Speci	fy)	Gi Me	emetery, cren Ipin M morial	anor	k	201	ıst 5,		Elkton,	
Ba	Depa Impo any i	9. 3	21. Signal re of Funeral Service Licen	thecho	)	22						or Funer kton, MI	rals, P.A. 21921
	Pnysician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final	plications that caused one cause on each line	the death	n. Do not ente			g, such as cardiac Abdomina			OUVICE )	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a	consequ	ence of):	71	MA	1 Section of	anorth	730	au 1 g sort)	
	ted	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as a	Consequ	rence ut;							
0	ath certificate be executed attending physician and for use as the burial-transit	ledical Examiner	that initiated events resulting in death) Last	Due to (or as a	consequ	ence of):							
68760	rtificate ling phy e as the		IF FEMALE:	00- 15									
. Box (	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ※ No 9 ☐ Unknown	23c. If yes, outcome of the line of the li	2 🗌 Feta	l death 3	Ectopi		У			23d. Date of de Month	llivery Day Year
ds, P.O.	luires that the dea in signed by the a uld be detached f		Part II. Other significant conditions of	ontributing to death b	ut not resu	ulting in the u	nderlyin	g cause giv	en in Part I.				o the cause of death?
Division of Vital Records,	The law require cate has been si page 2 should I	Completed by								24a. Was auto perfo 1 \sum Yes	psy ormed?	prior to death?	rtopsy findings available completion of cause of
tal	ician:	Be	25. Was case referred to medical examiner?	Hospital:					ace of Death (Che			<u> </u>	
of Vi	g Physier this ceral direction	e: 10	1 ☐ Yes 2 🔼 No 27. Manner of Death	1 Inpatie	у	ER/Outpatien 28b. Time of	nt 3 🗌	28c. Injury	4 □ Nursing F at	lome 5 🔀 Resi 28d. Describe 1		6 Other (Specury occurred	cify)
ion	tending Jeath. Ior: Afte the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not b	9		injury	М		? Yes 2 \( \subseteq No				
Divis	To the Hospital or Attending Physician: within 24 hours after death of the Funeral Director. After this certific completed filled in by the funeral director,	al Cert	4 Homicide determined	building, etc	. (Specify)	)				City or Tov	vn, Sta	te)	ral Route Number,
	he Hosp in 24 ho ne Fune pleted fi	Medical	(Check 2 Medical Exam	sician: To the best of iner: On the basis of ex se Practioner: To the l	amination	and/or invest	igation, i	n my opinio	n, death occurred	at the time, date	and plac	ce, and due to the	cause(s) and manner stated.
	To the comment		29b. Signature and the of certifier		1.0			9c. License			29d. E	Date signed (Mont	
			30. Name and address of person who	completed cause of de	ath (Item	23a) (Type, P	rint)		62190			-	011
٧	- OI-		SHAHNAWAZ KI	37 Registra	AU 6	USTIN	E HE	RMAN	Hwy, Su	TEA, CI	te sa	APEAKEC	21915
	Stat	е	31. Date filed (Month ) G, (19 20	11	. J Jigi iat	1		<b>*</b>					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25366 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $J_{\rm ulv}^{\rm Month}$  22. 12:45 P M Duggard Lucinda Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Fort Washington Fort Washington Medical Center 8. Date of Birth Month, Day, Year May 9, 1921 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** Months 1 🗆 M 2 🌠 F Illinois Director 361 18 1081 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2XXNo Maryland Fort Washington Prince George's 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20744 1446 Potomac Heights Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No If Yes, Give XX Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 WNo Specify: Specify: Black "natural", 3 ₩Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Accountant traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be fix th and Mental h ည Mary Boone Stephen Frazier permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Camp (Daughter) 6009 Coffer Woods Court, Burke, Va 22015 20a. Method of Disposition
1 □ Burial 2 🛣 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Clinton, MD Lee Crematory July 25, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat /9 of Funeral Se // e Liger see <sup>22. Name and Address of Facility</sup> Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwe shock, or heart failure. List only one cause on each line. Onset and Dea Immediate Cause (Final disease or condition resulting in death) Physician. N Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate outco. Enter Underlying Examine as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and attending physician Physician/Medical certificate be Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Hospital or Attending Physician: The law requires that the death of 24 hours after death.
 Funeral Director: After this certificate has been signed by the attention. in the past 12 months?

1 Yes 2 No
9 Unknown for Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1 þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed to the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 2 No 1 🗌 Yes 2 🗆 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**O Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes မ 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NBS State

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

Amir Mirza- Alikhani, M.D. 11711 Livingston Road, Fort Washington, MD 20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25367 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ Roberta Darlene Elrod 5:00 P M July 1 25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Prince George's Hospital Center Cheverly If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours January 8, 409-74-5160 66 Johnson City, Director 1945 Usual Residence of Decedent Show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Bladensburg Maryland 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò and Mental Hygiene. 'is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be p Funeral 5310 Upshur Street 20710 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry VA Hospital Elementary/Seconday (0-12) College (1-4 or 5+) Dental Assistant Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fred Higgins Edna Bryant 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren L. Elrod / Husband 5310 Upshur Street, Bladensburg, MD 20710 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 7/30/2011 Alexandria, Virginia 4 Donation 5 Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator roximate NV I Between et and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions. if any leading to immedicause. Enter Underlying Exam burial-transi Cause (Disease or linjury that initiated events resulting in death) Last attending physician Physician/Medical death certificate be Box 68760 as the nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day 5 Other (specify) Pregnant at time of death signed by the a ped Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ Records, No 1 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law to 24 hours after death.
 Funeral Director: After this certificate has be a funeral Director. page 2 autops 1 Yes 2 🗌 No Division of Vital Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes ဂ Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Deatl 28b. Time of ë 28c. Injury at 28d. Describe how injury occurred injury 5 Pending Natural work? Certifical 2 No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day)

State

Registrar

and address

LMO

7 2011

npleted cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep				25260
			Registrar	rtificate of Death	Reg. I	6.	25368
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year 2011	3. Time of Death
	Medic	al	CHARLES E. ELLIOTT				3:20 P M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		lc. County of Death	İ
	Funeval		HOLY CROSS HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	SILVER SPRIN	8. Date of Birth	MONTGOM a Birt	ERY hplace (State or Foreign
	Funeral Director		577-54-4129 11X M 2 F 70 Yrs.	Months Days Hours Min.	(Month, Day, Year JAN. 29,	1941 WA	intry) SH. D.C.
-			Usual Residence of Decedent		07111. 273	1741 WZ	BIII DIGI
	sho d at	tor	10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary 28a-1 otifie	Director	D.C. NONE	WASHINGTON			1 XYes 2 ☐ No
	h the taor ben		10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Co	untry?
	h with	Funeral	1221 M ST. N.W.	20005		U.S.A	
	deat r iten iner r		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	after al", o xami	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give  3 Widowed 4 XDivorced Year or Dates.	1 ☐ Yes 2X No Specify:		Spacifus	LACK
ခု	atura cal E	Completed		dent's Usual Occupation	16h	Kind of Business I	
212	an "n Medi	mp	(Specify only highest grade completed) (Give	kind of work done during most of worki	ing 105.	Talla of Business i	industry
7	withir giene er th		12	HANDYMAN		SELF EMP	LOYED
D D	filed within 72 hours after death with the Maryland tal Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be (	17. Father's Name (First, Middle, Last)	UNK . 18. Mother's Name	e (First, Middle, Maide	n Surname)	
<u>yla</u>		욘		V:	IOLA SI	MPSON	
Maryland 21215-0036	an is		I I	ing Address (Street and Number or Rura	il Route Number, City	or Town, State, Zip	Code)
<u>ر</u> س	1 and 2 soft Health item 27 other tr			30 LAURELWALK DR.,			
0	Page 1 anent of Faunt of Faunt: If ite		1 X Burial 2 Cremation 3 Removal from State cemetery, cre	matory or other place)		Location - City or	
Baltimore,	it. Pag rtmer rtant rjury			OLN CEMETERY 7-28		RENTWOOD,	
Ba	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service Scensee M00091	2. Name and Address of Facility CHAMBERS FUNERAL 1 5801 CLEVELAND AVI	HOME & CRE	MATORIUM ALE, MD	PA37
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en			11113 1110	Approximate
-	hysician/		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  NON SMALL CELL LUN	IC CANCED		}	Interval Between Onset and Death YEAR
	Medical		resulting in death)  a. NON SPARE CELL LOP  Due to (or as a consequence of):	IG CANCER			TEAK
	Examiner	<u>.</u>	Sequentially list conditions.	SYNDROME			WEEKS
	р <del>;</del> Д	Examiner	if any, leading to immediate cause. Enter Underlying			1	
	be executed sician and burial-tansi	Exal	Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):				
2	be e siciar buri	dical					
09/	certificate nding physuse as the	ledi					
8	certif	ın/k	IF FEMALE:   23c. If yes, outcome of pregnancy   1	Ectopic pregnancy		23d. Date of del	ivery
ROX	death he atter	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5			Month	Day Year
0	that the oned by the detache	Phy	9 Unknown				
J.	tha nec	by	Part II. Other significant conditions contributing to death but not resulting in the				the cause of death?
Hecords,	requires been sig	Completed	BONE METASTASES, CACHEXIA FROM CAN	CEK			
ပ္တ	law r has b e 2 sl	mpl			24a. Was an autopsy performed/	prior to o	topsy findings available completion of cause of
ř	icate icate r, pag		25 14		1 Yes 2 🗷		2 X-No
<u>ta</u>	siciar certif recto	0	25. Was case referred to medical examiner?  1 Ves 2 No Hospital:	26. Place of Death (Check			
7	Phys r this eral d	e: To	27. Manner of Death 28a. Date of injury 28b. Time of		me 5 Residence 28d. Describe how in		ify)
Z Z	nding ath. :: Afte e fune	cat	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No		,	
Division of Vital	er deg ector	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street		ral Route Number,
2	ital or Irs aft ral Dii led in				City or Town, Sta		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	edical	29a. Certifier (Check (Check only one) 3 ☐ Certifying Physician: To the best of my knowledge, death (Check only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at	the time, date and pla	ce, and due to the	cause(s) and manner stated.
	To the within To the complete	Σ	only one) 3 $\square$ <b>Certifying Nurse Practioner:</b> To the best of my knowledge, 29b. Signature and title of certifier	29c. License number		e(s) and manner as Date signed (Month	
			Farbara Supanich, RSM MI	D 006548	5	07/18/	//
			30. Name and address of person who completed cause of death (Item 23a) (Type,				
				REST GLEN RD., SII	LVER SPRIN	G, MD. 20	0910
	Stat Registra	e	31. Date filed (Month, Day, Year)  JUL 25 2011  33 Registrar's Signature	200			
			in the second of the second				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5:47 P Ronald Russell Frederick July 28, 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Washington Hancock 14721 Heavenly Acres Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 M M 2 □ F Birting. Country) PA **Funeral** Months 11/26/1939 71 Yrs Director 169-32-3417 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Hancock Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21750 USA 14721 Heavenly Acres Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖁 No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Distribution Warehouse Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Day Joseph Frederick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14721 Heavenly Acres Hancock, MD 21750 <u> Victoria E.Frederick/Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 08/01/2011 Big Cove Tannery, PA 4 ☐ Donation 5 ☐ Other (Specify) Damascus Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 M00260 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ DEMENTIA MULTI-INFANCT OYAS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 10 yns MANSIENT Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Vear 2 🗌 No g 🗌 Unknown as been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy pade death? 2 No 1 Yes 2 No 1 Yes the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 4 \( \square\) Nursing Home 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) injury 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

70051395

1110 MEDICA CAMPUS RO. SUITE 107

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2011

21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 21 Physician/ Month Year 07:30 AM 7 Richard G. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Carroll Assisted Momt An orien 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex If Und **Funeral** Sept. 1, 1926 Pennsylvania Months Hours Min. 135-20-7930 84 **Director** birth cert. Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14018 Peddicord Road 21771 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 

Yes 2 □ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: White 3 XWidowed 4 ☐ Divorced WWII Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meu College (1-4 or 5+) Elementary/Seconday (0-12) Bookkeeper Health Services Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pau1 Foltz Meta Graybill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6550 Rolynn Drive, Woodbine, Maryland Valerie Hobbs - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State Parklawn Mem. Park July 25, 2011 Rockville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 21. Sign ure of Puneral Service License nevert 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ System Medical resulting in death) Due to (or as a consequence of **Examiner** ymphoma Faculations if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Jaundice To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Weeks attending physician for use as the buria Physician/Medical Renal Insufficience Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Pregnant at time of death 5 Other (specify) 2 No Yes been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 has 1 Yes 2 No this certificate within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 2\ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1√Z Natural work' 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) of ertifie 29b. Signatu 21/11

2041

State Registrar

1502 S. Main St.

egistrar's Signature

breun.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

have

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31. Date filed (Month

10070147

Mt. Airy

MD 21771

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	laryland	-	rtment of ⊢ tificate of D		Mental Hy	giene <sub>Reg. N</sub> 2 (		25371
	Physicia	n/	1. Decedent's Name (First, Middle, L.	ast)					2. Date of Dea	ath		3. Time of Death 1030 AM M
	Medic Examin	al	Edith Friedman  4a. Facility Name (If not institution, gir				4b. City, Town, or	Location of Death	<u> </u>	<u> </u>	nty of Death	
			The Hebrew Home				Rockvi  If Under 1 Year	11e If Under 24 Hrs.	Lo Barrella			
	Funeral Director			Sex 1 ☐ M 2 F 7. Aq	ge (In yrs. las 87	Yrs.	Months Days	Hours Min.	8. Date of Birt	923	MACou	nplace (State or Foreign Intry)
	nd thow at	o.	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
	Maryla 28a-f s otified	irect	FL Palm Be	each	Boyn	ton Be	each					1 X Yes 2 □ No
	ith the	Funeral Director	10e. Street and Number 8057 Key West La	ine			10f. Zip Code 33472			10g. Citizen Unite		
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	β	11. Marital Status  1  Never Married 2  Married	12. Was Decedent Armed Forces?		If	√as Decedent of Hi Yes, specify Cuba	n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	E	Race - Amer Black, White	, etc.
00-0	hours a	letec	3			16a. Deced	ent's Usual Occupa	ation	lina	16b. Kind o	f Business I	ndustry
121	thin 72 ene. than " he Mec	Completed	(Specify only highest (Seconday (0-12)	College (1-4 or	5+)	life. DO	and of work done d NOT use retired) emaker	unng most of wor.	KING	Own 1	Home	
Maryland 21215-0036	be filed wi ental Hygie <b>'ked other</b> ic event, t	To Be (	17. Father's Name (First, Middle, Last Reuben Gordon	t)				18. Mother's Nar Pearl A		Maiden Surn	ame)	
Aary	should and M is mai raumat		19a. Informant's Name/Relationship			19b. Mailin	g Address (Street a	and Number or Ru	ral Route Numbe	r, City or Tow	n, State, Zip	Code)
re,	of Health of Health fitem 2: rother t		Lois J. Goodstei		20b. Pla	ce of Dispos	sition (Name of	-	Date	20c. Locati		
Baltimore,	permit. Page 1 Department of Important: If it any injury or conce.		1 ⚠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	³ B'Na		hatory or other place th Cemete		22/11	Worce	ster,	MA
Ba	permii Depar Impor any in		21. Signature of Funeral Service Lice	MO 1	H163	Da	Name and Address Anzansky II/O Ro	ss of Facility Goldberg ckville	Memori Pike Ro	al Cha ckvill	Pels :	Tn852
			23 Sact 1. Enter the disease, or co shock, or heart failure. List only									Approximate Interval Between Onset and Death
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Denue to (or as	_	nce of):						Oriset and Death
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	of a stee	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as	a conseque	ince on,						
_	oe exectician a	al Ex	resulting in death) Last	Due to (or as	a conseque	ence of):						
3760	ficate by g bhysias the b	Medical		d								7.1
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-target.	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant 9  Unknown	2 Fetal at time of de	death 3	Ectopic pregnand Other (specify)	ey .		23d	. Date of del Month	ivery Day Year
s, P.O.	ires that the signed by Id be detac	d by Ph	Part II. Other significant conditions	contributing to death	but not resul	Iting in the u	nderlying cause giv	ven in Part I.				the cause of death?
Secord	he law requ te has beer age 2 shou	Completed							24a. Was auto perfo	psy ormed?	prior to death?	topsy findings available completion of cause of
tal	cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:			26. Pl	ace of Death (Che	ck only one)			
of Vi	g Physi er this c eral dir	은: -	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpa 28a. Date of inj (Month, Da		28b. Time of	28c. Injur	4 📉 Nursing F y at	fome 5 Resi 28d. Describe		-	ify)
ion	tending leath. tor: Afte the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no	ion		injury		Yes 2 No				
Oivis	al or At s after o il Direct d in by		4  Homicide determine	28e. Place of in	ijury - At nom tc. <i>(Specify)</i>	ne, tarm, stre	eet, factory, office		City or To		imber or Hu	ral Route Number,
	he Hospit in 24 hour he Funera pleted fille	Medical	(Check 2 Medical Exa	hysician: To the best o miner: On the basis of urse Practioner: To the	examination a	and/or invest	tigation, in my opinio	on, death occurred	at the time, date	and place, and	d due to the	cause(s) and manner stated.
	So de la constante de la const		29b. Signature and title of certifier				29c. Licenso			29d. Date si	-	
			30. Name and address of person wh	o completed cause of	death (Item 2	23a) (Type, F		4871		( - 01	0-20	
			Mina Fazli, M	ND 6121	Montr	ose R		Kville	WP :	20858	2	
*	Star Registra		31. Date filed (Month, Day, Year) JUL 25 2	011 Seken	rar's Signatu	. La	Nest.					

Registrar

2 6 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Mildred Goldman July 21 9:51pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Collingswood Nursing Home Social Security Numbe 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 8. Date of Birth **Funeral** Country) New York July 21, 1920 1 M 2 X F Months Days Hours Min. 578-32-8957 **Director** 91 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20816 U.S.A. 5101 River Road, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Caucasian the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service Postal Associate permit. Page 1 and 2 should be filed n Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Specht Robert Goldman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5101 River Road. #418. Bethesda, Maryland 20816 Beatrice Root - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Sunal 2 ☐ Cremation 3 ☐ Removal from State King David Mem. Grdns 07/24/2011 | Falls Church, Virginia Donation 5 Other (Specify 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Signatu / of Fur ral Service Licen / e NW0709 11800 New Hampshire Ave., Silver Spring, MD 20904 Harry 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause Pha Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Secreptially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-track or Attending Physician: The law requires that the death certificate be executed Coronary Artery Disease Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and de detached for use as the burial-tra-Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed page 2 should peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No. has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 [X] Nursing Home 5 - Residence 6 - Other (Specify) 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 👿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certi

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Date filed (Month, Day, Year)

25 2011

D30132

Rita Ghosh, M.D., P.C., 14812 Physicians Lane, #161, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year)

July 22. 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25374 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0254 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Crofton 1688 Barrister Court g. Birthplace (State or Foreign . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 1 M 2 | F Months Days Hours Min. 214-52-6080 0192471947 Washington, D.C Director 64 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified Crofton MD Anne Arundel 1 Tes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21114 1688 Barrister Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No filed within 72 hours after 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Director Verizon marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carolyn Williams Darrin Hagist Gridley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1688 Barrister Court, Crofton, MD 21114 Carol Irey Gridley/Spouse other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit, Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gardens 07/25/2011 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, MD 21. Signature of Funeral Service Licensee Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause Final disease or condition resulting in death) Onset and Death Physician/ ASTA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 1 Yes 2 g Unknown 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 this certificate has 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician; To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title <del>of c</del>ertifier 2011 20

Registrar
DHMH 17 Rev 7/2009

State

TENEDIEVE

Baltimore, Maryland 21215-0036

Box 68760

Records,

**Division of Vital** 

ause of death (Item

Registrar's Signature

IGAI

5 2011

DEFENSE HWY, ANNAPOLIS, MD21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		_	1 - State Registrar	Certificate of Death	Reg. No	011 25375
	Physicia		1. Decedent's Name (First, Middle, Last)  Brenda Doreathea Hurley		2. Date of Death  Month July 25, 2011	3. Time of Death 6:05 AM
	Medic Examin		4a. Facility Name (if not institution, give street and number) Fort Washington Health & Rehabilitation	4b. City, Town, or Location of Death Fort Washington	4c Cou	inty of Death ace George's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda $1 \square M 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$	Months Days Hours Min	8. Date of Birth (Month, Day, Year) NOV 28, 194	9. Birthplace (State or Foreign Country)
	and show dat	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	e Maryl r 28a-f notifie	Director		shington		1 ☐ Yes 2 🌠 No
	s 23a or	Funeral L	8927 Rusland Court	10f. Zip Code 20744	10g. Citizen USA	of What Country?
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Yes 2 ☒ No  If Yes, Give  Year or Dates.	13. Was Decedent of Hispanic Origin? (Sperif Yes, specify Cuban, Mexican, Puerto & 1   Yes 2 X No Specify:		Race - American Indian, Black, White, etc. Cify: Black
215-(	n 72 hor e. ian "nat Medica	Completed	(Specify only highest grade completed) (G.	ecedent's Usual Occupation ive kind of work done during most of workir e. DO NOT use retired)	ng 16b. Kind o	f Business Industry
721	d within Hygiene. ther thar nt, the M	امها		cutive Assistant		al Government
/lanc	nould be filed with and Mental Hygier marked other t amatic event, th	인	Theodore Buchanan		e (First, Middle, Maiden Surna ae Matthews	ame)
, Mary	id 2 should I salth and Me n <b>27 is marl</b> er traumati		19a. Informant's Name/Relationship (Type, Print)  19b. M  1805	lailing Address (Street and Number or Rura Klowstad Dr., Fort Wash	Route Number, City or Town nington, MD 20744	n, State, Zip Code) 1
Baltimore, Maryland 21215-0036	Page 1 an ment of He ant: If iten ury or oth		1 Burial 2 X Cremation 3 Bemoval from State cemetery, of	sposition (Name of crematory or other place)  Park Crematory 7/26/2		on - City or Town, State
Balti	permit. Departr Importa any injt		21. Signature of Funeral Service License	22. Name and Address of Facility J. K 6503 Old Branch Ave., Te		
	Physician Medical Examiner		23a. Part 1. Enter the disease, or conjournations that caused the death. Do not stock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	enter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death
	LAMIIIIIEI	ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	what his	reshals	2
	ificate be executed g physician and as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  C. Due to (or as a consequence of):			
8760	te be ex hysiciar he buria	<b>Nedical</b>	d			
Box 687	Attending Physician: The law requires that the death certificate be executed ar death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Date of delivery Month Day Year
, P.O.	ss that th igned by be detac	þ	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		ontribute to the cause of death?
ords	require been s should	Completed				b. Were autopsy findings available
Rec	: The lay cate has	Com			autopsy performed  1  Yes 2 No	prior to completion of cause of death?  1 □ Yes 2 □ No
Vital	ysician is certifi director	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	26. Place of Death (Check	me 5 Residence 6 0	Other (Specify)
n of	nding Ph ith. After thi funeral		27. Manu of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day, Year) injury injury	e of 28c. Injury at 2	28d. Describe how injury occ	
Division of Vital Records,	al or Atter s after des I Director d in by th	Certificate	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Nur City or Town, State)	mber or Rural Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	29a. Certifier  1 Certifying Physician: To the best of my knowledge, dear (Check 2 Medical Examiner: On the basis of examination and/or in only one) 3 Certifying Nurse Tagtioner: To the best of my knowledge.	vestigation, in my opinion, death occurred at	the time, date and place, and	due to the cause(s) and manner stated.
	To the within 2 To the I comple		29b. Signature and title of certifier	29c. License number  29c 24535		gned (Month, Day, Year)
D	1		30. Name and address of person who completed cause of death (Item 23a) (Typ Laxmi Berwa, MD 7700 Old Branch Av		, MD 20735	
	Stat Registra	e	31. Date filed (Month, Pay Year) 32. Registry's Sign was the			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25 Day 2011 11 00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9. Birthplace (State or Foreign Montgo wer Genera Hospita Olney If Under 24 Hrs 8. Date of Birth If Under 1 Year **Funeral** Country) Jordan 1 🗆 M 2 🍱 F Year)933 Months Hours Min March 8, 78 Director 213-84-4658 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location Director 1 Yes 2 No MD Rockville Montgomery 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 14219 Chesterfield Road 20853 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rizekalleh Hassan Hanieah Samawi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14219 Chesterfield Road, Rockville, MD 20853 Salim H. Haddad/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery July 29 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2/ Cremation 3 Removal from State Silver Spring ,MD 4 Donatien 5 Deher (Specify) . Signature of Funeral Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) piratory Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed for use as the burial-transi Obstructue Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Pregnant at time of death be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hypertansian Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N after death.

Director: After this certificate | 1 Yes 2 No or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 No 1 🗌 Yes 1 npatient 2 -ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 5 Pending Natural work? 1 🗌 Yes 2 No Accident Suicide Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State). determined To the Hospital o within 24 hours aff To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and equanner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Division of Vital

Hospite

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | 3 | 0 | Prince

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Registrar's Signatur

Montgomen

JUL 2 7 2011

31 Date filed (Month

D 69086

Philip. Dr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $J_{uly}^{Month}$ 22 pay 201°1 Van Jacobs Lavoy 1:05A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carrol1 627 Calliope Way Mount Airy 8. Date of Birth (Month, Day Ye Aug . 15, Social Security Number If Under 1 Year | If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1 XM 2 □ F Days Year) 1922 Hours 549-36-4955 88 Nebraska Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. antit if item 27 is marked of ther than "natural", or items 23a or 28a-f sho antit if item 27 is marked of ther than "natural", or items 23a or 28a-f sho uny or other traumatic event, the Medical Examiner must be notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Carrol1 Mount Airy 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 627 Calliope Way 21771 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify:Whi<u>te</u> 3 XWidowed 4 ☐ Divorced Completed Korean Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Asst. Director of Supply & Be 18. Mother Starte (1913), Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Pau1 Ε. Jacobs Madge Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Jacobs - Son Clairemont Drive, Owings, Maryland 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 Burial 2 Xremation 3 Removal from State 4 Denation 5 Other (Specify) Metropolitan Crematorium 7/23/1 Alexandria, Virginia 21. Signature of Funeral Service Censes 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home liam 26401 Ridge Road, Damascus. 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ADDE CAWCE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, il any cause. Enter Underlying Cause (Disease or linjury Due to for as a consettience of Exami After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy Hospital or Attending Physician; The 124 hours after death.
Funeral Director. After this certificate h performed? Yes 2 No 1 Yes 2 🗌 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{X} \) Residence 6 \( \text{Other} \) Other (Specify) 2 🛚 No 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one and title of certifie 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year)

State Regist<u>rar</u>

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DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. R gistrar's Signature

David B. Harding,

31. Date filed (Month,

2 5 2011

D35965

18111 Prince Philip Dr., Suite 300, Olney, Md. 20832

July 22, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State
Registra MEND#7+8perFH, 7/26/11; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 24, 2011 М 1723 Sterling Jackson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Silver Spring Woodside Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, June 9,1 **Funeral** 9. Birthplace (State or Foreign Min. 1 X M 2 □ F <del>60</del> 50 Yrs. Washington, DC **Director** 577-90-6429 June 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director DC N/A Washington 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 Tewkesbury Place, N.W. 20012 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc.n-Yes 2 X No 1 X Never Married 2 Married ð Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 K No Specify: "natural", 3 Widowed 4 Divorced Specify: American Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Worker Metro Transit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Carrie Lee Washington Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 930 Tewkesbury Place, NW Washington, DC 20012 Nelson C. Johnson/Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 07/26/2011 Beltsville, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee 7400 Georgia Avenue, N.W. Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Metastatic Prostate Cancer Physician/ Months Medical resulting in death) Due to (or as a consequence of): Examiner Weeks Multiple abcesses Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) e attending physician and ed for use as the burial-tract Days To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death P.O. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Hemiplegia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛂 Unknown Records, Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 N death? 2 🗌 No Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) July 25, 2011 29b. Signature and title of certif D0068583 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9101 2nd Avenue Silver Spring, MD 20910 Tanyech Walford, M.D.31. Date filed (Month, Day, Year) 32. Registrar's Signature State 26 JUL Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Nowal Larre 0330 cm 10k Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 🗆 F Days Hours Min. 217-64-9554 57 **Director** Washington, D.C. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Bowie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20720 5320 Lakevale Terrace USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2X Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates f and 2 strough of the first and Mental Hygiene.
Health and Mental Hygiene.
Hem 27 is marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Prince George's County Retired Policeman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas A. Kane Mary Shepherd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2: Department of Health Ruth A. Kane/Spouse 5320 Lakevale Terrace, Bowie, MD 20720 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Mem. Gardens 07/27/2011 Davidsonville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line. Xastatic Onset and Death Immediate Cause (Final Rectal Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical that the death certificate be 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, Hospital or Attending Physician: The law requires 24 hours after death. 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? this certificate 1 Yes 2 No Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 2 Accident
3 Suic 1 Natural 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 29 D 21438 21 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 DEFENSE ITUY ANNAPOLUMN 21401 AW 445 MICHAEL aTEN egistrar's Signature 25 2011 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month July Physician/ Albert. Klevan 2011 7:55 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing Home Rockville Montgomery 5. Social Security Number last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days April Day Ye 1 **™** M 2 □ F Months Hours Min Director  $\stackrel{Country)}{\operatorname{Md}}$ 218-18-6491 1922 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ohm any injury or other traumatin avant the state of 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Md. Montgomery Olney 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16737 Gooseneck Terrace 20832 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 White 1942-1943 <sup>1 □</sup> Yes 2 No Specify 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Rusiness Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Technical Illustrator Government Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David Klevan Lena Perkal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Zeller/Daughter 16737 Gooseneck Terrace Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Bemoval from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Judean Cemetery 7/21/11 Olney, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Edward Sagel Funeral Direction
1091 Rockville Pike Rockville, Md. Ele M00910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Alzheimers dementia Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Congestive Heart Failure Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burian (a) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K No After this certificate 2 No 1 Yes npleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury Natural 5 Pending within 24 hours after death. To the Funeral Director: A Accident M 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D0056345 7/20/2011

State Registrar 31. Date filed (Month, Day, Year) **JUL 2** 5 2011

Piyush

Patel

Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

19745 Executive Park Circle Germantown, Md. 20874

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 1500 Steven 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Howard Columbia 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 ☐ F 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Davs Hours 472471933 S.Korea Director 216-80-2476 78 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Glenelg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3840 Ivory Road 21737 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian If Yes, Give Year or Dates 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired Elementary/Seconday (0-12) Office Clerk W.M.A.T.A. should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Chun Young Park Won Jin Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3840 Ivory Road Glenelg, Maryland 21737 permit. Page 1 and 2 st Department of Health a Important: If item 27 is Helen W.Kim/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 7/26/2011 Silver Spring, Md 4 ☐ Donation /5 ☐ Other (Specify) Gate of Heaven 21. Signature of PHTETPADOSRINALDI FUNERAL SERVICE P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ aspiration DRUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events and-tran resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical The law requires that the death certificate be Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown Year ed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 4No 1 Yes of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 PNo Other: မ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 7/2009 00066515

Colorina GAREWAY DR. Colorina.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rawat Day, Year) L 25

31. Date filed (Mont)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 25382 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 21, 2011 Gertrude J. Kerner 5:55 рМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Village P.G. Silver Spring If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country)
 C **Funeral** Age (In yrs. last birthday) 8. Date of Birth Hours 1 M 2 X April 22 Year 1926 578-24-3248 85 D.C. Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at death with the Maryland Director MD 1 Yes 2x No Silver Spring Prince George's 10e. Street and Number 10f. Zip Code ō 10g, Citizen of What Country? 23a Funeral 3160 Gracefield Road, OG-3344 20904 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 2 þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: White "natural", Completed | 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working jife. DO NOT use retired) Decedent's Education. 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bernard Kober Dorothy Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Joseph Kerner/Son 6712 Woodridge Road, New Market, MD 21774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ott cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State July 22 2011 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA Signature of Funeral Service Licens 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring.MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death day Immediate Cause (Final Physician! Pneumonia Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a nonsequence of) cause. Enter Underlying buria speci Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy
5 Other (specify) in the past 12 month
1 Yes 2 X No detached for Month Day Year Pregnant at time of death the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure, Alzheimer's Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 No 2 K No Yes To the Hospital or Attending Physician: sompleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: AND Nursing Home 5 Residence 6 Other (Specify) ပ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who

31. Date filed (Month, Day, Year,

Eileen Gemmell, CRNP

25 2011

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

5866

3160 Gracefield Road, Silver Spring, MD 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar 25384 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ THOMAS WILFERD LIVERS, SR. JULY 30 2011 Year 12:10AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 9655 BROCKTON PLACE FAULKNER Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Months Days (Month, Day, Year) 17 MD • 220-16-4875 93 Yrs **Director** Usual Residence of Deceder show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD. CHARLES FAULKNER 1 Yes 2 No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 9655 BROCKTON PLACE 20632 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No AR 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event. The Manage injury or other traumatic event. 1 Never Married 2 X Married ģ ARMY Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industr (Specify only highest grade completed) LA PLATA HIGH SCHOOL Elementary/Seconday (0-12) College (1-4 or 5+) CHAS.CO.BD.OF EDUC. CUSTODIAN 7th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JAMES MUDD LIVERS HENRIETTA HICKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MARY LIVERS-SPOUSE 9655 BROCKTON PLACE FAULKNER, MD. 20632 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burlal 2 ☐ Cremation 3 ☐ Removal from State ST. IGNATIUS CEM. 8-5-11 CHAPEL POINT, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foreral Service Licer MO0479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami and -tran Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day 2 No the 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? Yes 2 XOo 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 00 |은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 30. Name and address of persor to completed cause of death (Item 23a) (Type, Print) C

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 = State Registra Amend#'s17.20a.b.c.PerFHP008-5-11crCertificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Death A Physician/ abar 1 Mes **Medical** 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Stewart House II 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) 1 XM 2 □ F Days Hours Min Months Yrs DC Director 87 226-20-3825 Sept. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural" any injury or other traumatic event. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 United States 1506 Liester Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married African American If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Completed 3 X Widowed 4 ☐ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Griffith Elementary/Seconday (0-12) College (1-4 or 5+) 12th Truck Driver 0i1 Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Henry Lewis unk. Mabel Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrna Fawcett-Guardian 2101 Connecticut Avenue NW #24 WDC Date unk. 20a. Method of Disposition unk. 20b. Place of Disposition (Name of unk. 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) August 8, Partlow, Virginia Coleman-Lewis Family Cem. 2011 4 ☐ Donation 5 ☐ Other (Specify) Funeral Home, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20019 10 4001 Benning Road NE Washington, DC 24 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Staci disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No q 🗌 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 

No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an Chronic renal autopsy performe death? Yes 2 No 2 🗷 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Living Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury ė; 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural N work? 1 ☐ Yes 2 ☐ No 5 Pending Certifical Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHROEDER hysicians tos 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Frances Ε. Lawson Medical 2011 July. 10:15A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Laurel Regional Hospita Prince George's Laurel Funeral Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 1 🗆 M 2 🔀 F Months Days Hours Min. (Month, Day, Director 579-42-8653 77 8/28/1933 Newberry. Usual Residence of Decedent "natural", or items 23a or 28a-f show 10a. State 10b. County the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Laurel 1X Yes 2 No with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14200 Laurel Pk 20707 permit. Page 1 and 2 should be filed within 72 hours after death \( \) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. U.S.A 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. 3 Widowed 4 N Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Gov't 12th LPN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cromer Melvin Subera Corrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 96 Herrington Dr. Upper Marlboro, MD 20774 James Lawson/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place esurrection Cemetery:7/29/2011 Clinton, MD Signature of Funeral Sept. I in need 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. N.W. Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a. Hypoxial Respiratory Acidosis Medical Examiner b. Acute Respiratory Failure Sequentially list conditions, Examine Due to (or as a sonscipuence of): cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Acute on Chronic Congestive Heart Failure Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be after death. P.O. Box 68760 <u>Bilateral</u> Pneumonia IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year Yes 2 XNo detached g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? After this certificate 1 Yes 2X No 1 Yes **Director:** After this certific in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗶 No Other: ပ 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier

State Registrar 30. Name and add

32. Registrar's Signature

ess of person who completed cause of death (Item 23a) (Type, Print)

D0012962 Laurel Regional Hospital

7300 Van Dusen Rd.

29d. Date signed (Month. Day, Year)

Laurel , MD 20707

7/24/2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	125		Dears he	Xpuesta	of my	D1	2121			Ju1	y 25,	201	1
	1		30. Name and address of person who George F. Sengs		th (Item 23a) (Type, F 3929 Ferra	Print)		War c	nrin-				
	Stat	e	31. Date filed (Month, Day, Year)	22. Registrar's	Signature		, 211	AET D	brrng,	rid .	70300		
	Registra		JUL 26 201		A. par	to.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $J_{u}^{\text{Month}}$ 23. 2011 2:30 A Calvin Bernard Mines Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7742 Finn's Lane Apt. B-1 Prince George's Lanham Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month Day, 1 🖾 M 2 🗆 F Months Days Hours Yrs **Director** DC 62 577-66-8315 lune Usual Residence of Decedent 28a-f shov 10a. State 10b. County ıral", or items 23a or 28a-f sho I Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Lanham Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7742 Finn's Lane Apt. B-1 20706 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify. "natural", 3 Widowed 4 A Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other the Copyright Specialist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Ment. Important: If item 27 is marked any injury or net. Mary Jeanette Craig William James Mines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric J. Mines - Brother 6302 Gallery Street Bowie, Maryland 20720 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1  $igspace{1}{8}$  Burial 2  $igspace{1}{9}$  Cremation 3  $igspace{1}{9}$  Removal from State cemetery, crematory or other place, Ju1y 28**1**1 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC Mt. 01ivet Signature of Furileral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, 4001 Benning Road NE Washington, DC Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode shock, or heart failure. List only one cause on such line. ardiac or respiratory arrest Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and trar Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical Box 68760 nding p IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregna 5 Other (specify) for in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death ed by the detached Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 2 No 3 Probably 4 Unknown Completed been signal 24a. Was an . Were autopsy findings available prior to completion of cause of has autopsy death? performed certificate 2 No Yes Division of Vital 25. Was case referred to medical Be examiner? Other: ျ 1 Yes 1∰Ainpatient 2 l ER/Outpatient 3 DOA 4 Nursing Home\_ 5 Residence 6 Other (Specify) this funeral n 24 hours after death.

e Funeral Director: After the pleted filled in by the funeral Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 🔲 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) ☐ Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 24 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and my 29b. Signature and title of certifie 29d. Date signed (Month.

State Registrar 30. Name and addre

Date filed (Month, Day,

o completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	tate of Maryland	Oepa <i>Cer</i>	irtment of H tificate of D	lealth and IV Death		ien 2011	25390
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	. MAR	LSH	ALL		2. Date of Deat Month	2 Day 201	3. Time of Death 5-50 P M
-	Examin		4a. Facility Name (if not institution, give street 16103 Allenglen Cour			4b. City, Town, or	Location of Death		4c. County of D	
1	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	2 Age (In yrs. las 85	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 11-28-1	925	Birthplace (State or Foreign Country Virginia
	show dat	tor	Usual Residence of Decedent  10a. State 10b. County		Town or Loc			_		10d. Inside City Limits
	he Mary or 28a-f notifie	Director	MD Prince Geo	orge's		Bowie  10f. Zip Code			10g, Citizen of What	1 ☐ Yes 2 🖾 No Country?
	th with the must be	Funeral	16103 Allenglen Cour		La	207			1	USA
920	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	क्	1 Never Married 2 Married 1	Vas Decedent Ever in U.S.	If	Vas Decedent of His Yes, specify Cubar Yes 2 X No	spanic Origin? (Spe n, Mexican, Puerto Specify:	city Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
15-0	n 72 hou an "natu Medica	Completed	15. Decedent's Education (Specify only highest grade co	mpleted)	(Give k	ent's Usual Occupa sind of work done d O NOT use retired)	ation Juring most of worki	ng	16b. Kind of Busine	
212	ed within Hygiene. rther thai	Be Co	Elementary/Seconday (0-12)  17. Father's Name (First, Middle, Last)	follege (1-4 or 5+) 5+		Teacher	18. Mother's Name	Eiret Middle 1		hools
yland	ld be filed Mental Hy arked oth atic event	의	Bryan Caufield					a Lee Sm		
Mar	and 2 should Health and Mr tem 27 is mar ther traumati		19a. Informant's Name/Relationship (Type, Pa Ann E. Craynon/Daug						City or Town, State, MD 20716	
nore,	Page 1 and ment of Hea ant: If item ury or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Remo	20b. Pla	metery, crem	sition (Name of natory or other place	ery 07/28	Date 3/2011	20c. Location - City	or Town, State , Virginia
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Heatt Important: If item 2 any injury or other i		4 Donation 5 Other (Specify)  21. Stylinatury Transition (Specify)			. Name and Addres	s of Facility Be	eall Fun	eral Home vie, MD 20	
	Physician/ Medical Examiner		23a Birt 1. Enter the disease, or complication shock, or heart failure List only one call immediate Cause (Final disease or condition resulting in death)	ons that caused the death.	ITC					Approximate Interval Between Onset and Death
	cate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque						
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	yes, outcome of pregnand Live Birth 2 Fetal Pregnant at time of de	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year
ds, P.O.	quires that then signed by ould be detail	þ	Part II. Other significant conditions contribu	iting to death but not resul	ting in the u	nderlying cause giv	en in Part I.			e to the cause of death?
Division of Vital Records,	: The law re icate has be r, page 2 sh	Completed						24a. Was a autop perfor 1  Yes	sy prior deat	e autopsy findings available to completion of cause of h? Yes 2  No
Vital	nysician nis certif I directo	To Be	25. Was case referred to modical examiner?  1  Yes 2 No Hospi	tal: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	Othe	er: 4  Nursing Ho		ence 6 Other (S	pecify)
on of	nding Plath. # After the funera		27. Manner of Death  1 Autural 5 Pending 2 Accident Investigation	8a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1	∕at ? Yes 2 □ No	28d. Describe ho	ow injury occurred	
Division	al or Atte s after des I Director d in by th	Certificate:	2 Cuicide 6 Could not be	Be. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Si City or Town		Rural Route Number,
_	ne Hospita n 24 hours ne Funera pleted fille	Medical	(Check 2 Medical Examiner: C	To the best of my knowled on the basis of examination of ctioner: To the best of my l	and/or invest	igation, in my opinio	n, death occurred a	t the time, date ar	nd place, and due to t	the cause(s) and manner stated.
	Some Some Some Some Some Some Some Some		29b. Signature and title of certifier	DSP	·	29c License	number 0	3	29d. Date signed (M	anth, Day, Year)
	2		30. Name and address of person who comple	eted cause of death (Item 2	23a) (Type, P	De La	nse H	my A	VNnesta	Mo21401
ı	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 5 2011	32. Registrar's Signatu	<i>b</i> . 4	back			7	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25391 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ DORIS MADDOX Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TRAUMA Social Security Number CENTE If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Davs Hours oct. 25, . 1964 1 🗆 M 2🏋 F 46 MARYLAND **Director** 219-86-0273 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location notified at Director 1 Yes 2 XNo INDIAN HEAD MD **CHARLES** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral UNITED STATES 20640 6955 JOHNSON PLACE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify: Specify. Completed 3 🗆 Widowed 4 🗆 Divorced BLACK Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) DAY CARE PROVIDER CHILD CARE 11**TH** traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o မ DOROTHY JUNE JOHNSON permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic EARL WALLACE MADDOX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6955 JOHNSON PLACE, B, INDIAN HEAD, MARYLAND 20640 JOMEKIA DUNNINGTON/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State BRINSFIELD-ECHOLS CREMATORY 8/2/2011 CHARLOTTE HALL, MD 4 Donation 5 Other (Specify) ty of Funeral Added Lives 4 1201A C. THURNION JURNSON MO0583 THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Due to ( r as a consequence of): FAILURE disease or condition Medical resulting in death) Examiner MYOCARDIAL INFARCTION Sequentially list conditions, Examine Jun to for as a consecuence of if any, loading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law equires that the death certificate be executed and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Xilio be detached for Day Pregnant at time of death 5 Other (specify) the 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed eeu 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ★ No 24a. Was an has autopsy performed? Yes 2 No direct r, page 2 certificate **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes 1 Ninpatient 2 ER/Outpatient 3 DOA Certificate: To 24 hours after death.
Funeral Director: After this 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Vatural injury 5  $\square$  Pending 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 🗆 only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) ES 000 25 ,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MO 22 REENE SI IREENWOOD 31. Date filed (Month, 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	se Type or P State of		d / Depa	ndelible In artment of I tificate of I	Health		•		_	25392
Physicia	n/	Registrar  1. Decedent's Name (First, Middle	, Last)		Cer	tificate of	Deam		2. Date of Dea		Vear	3. Time of Death
Medic Examin	al	John Cl  4a. Facility Name (if not institution,	narles give street and numbe	r)		Mastroun:		of Death	July	2 6 4c. Count	<b>2011</b> y of Death	9:55 A M
Funeral		321 S. Cannon  5. Social Security Number	6. Sex 7.	Age (In yrs. k	ast birthday)	Hagers If Under 1 Year	If Under		8. Date of Birtl	h	hingt g. Birt	ton
Director		212-38-8422 Usual Residence of Decedent	1 <b>X</b> M 2 □ F	70	Yrs.	Months Days	Hours	Min.	(Month, Day 9/8/19	, Year) 40 	Ma	ryland
aryland a-f shov fied at	Director	10a, State 10b. County		10c. City	y, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 🐪 No
a or 28 be noti	at Dire	MD Washir  10e. Street and Number	igton		Hagers	10f. Zip Code			Γ	10g. Citizen of	What Co	
ath with	Funeral	321 S. Cannon	Ave.	nt Ever in II.9	13 \	21740 Was Decedent of F		igin? (Spe	cify Yes or No-		S.A.	rican Indian.
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland beatment of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Marr 3 Widowed 4 Divorced	ied Armed Force 1 ☐ Yes 2 If Yes, Give	s? No	'	f Yes, specify Cub	an, Mexica	n, Puerto I	Rican, etc.)		ck, White	e, etc.
2 hours "natura edical E	Completed	15. Deceder	Year or Dates nt's Education st grade completed)	5.	16a. Deced	dent's Usual Occup kind of work done	oation during mos	st of worki	7G	16b. Kind of I		ndustry
within / giene. er than , the Mo		Elementary/Seconday (0-12)	College (1-4	or 5+)	Ìife. D	0 NOT use retired, <b>00k</b>				Frater	nal O	rganization
ntal Hyged other sevent,	To Be	17. Father's Name (First, Middle, L					18. Moth		(First, Middle, I	Maiden Surnan	7e)	
should be and Me is mark sumatio		Charles Presgr 19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street	and Numb		abeth M   Route Number			Code)
and 2 s Health em 27 ther tra		Ruth N. Mastrou 20a. Method of Disposition	ınni / Spou			Fredell A	ve.,		cer, NC	28159 20c. Location	- City or	Town State
Page 1 ment of ant: If it ury or c		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate C	emetery, crem	natory or other pla en Cemete			/2011		,	, Maryland
permit. Departi Import any inji		21. Signature of Funeral Service L	icensee	.00		Name and Address						
hysician/		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition	complications that cau nly one cause on each	sed the death line.		er the mode of dyin		cardiac o	r respiratory arm			Approximate Interval Between Onset and Death
Medical physician and attending physician and for use as the priral-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or a	as a consequal as a c	n pr	iman		un (				2 months
begins that the attending physici should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 Live Birl 4 Pregnar 9 Unknow	th 2 🗌 Fetant at time of c	Ideath 3	Ectopic pregnan Other (specify)	су				ate of del	ivery Day Year
gned	þ	Part II. Other significant condition	ns contributing to deat	h but not res	ulting in the u	nderlying cause g	ven in Part	1.		bacco use cor ∕es 2 □ No		the cause of death?
icate has be	Completed	05 Was 200 of the last line in the second							24a. Was a autop perfor 1 Yes	sy	prior to death?	topsy findings available completion of cause of
is certif	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	atient 2 🗌	ER/Outpatier	_ Oth	lace of Dea er: 4   N		only one) me 5 Resid	ence 6 🗆 Ot	her (Speci	ify)
th. After th		27. Manner of Death  1 Natural 5 Pendin 2 Accident Investic	9	njury Da <i>y</i> , Yea <i>r)</i>	28b. Time of injury	wor			28d. Describe ho	ow injury occur	red	
after dea Director	Certificate:	3 Suicide 6 Could a determine	not be 28e. Place of	Injury - At ho etc. (Specify,		eet, factory, office			28f. Location (S City or Town		ber or Rur	ral Route Number,
to the rope of which and the completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2	Medical	(Check 2 Medical E	Physician: To the best xaminer: On the basis of Nurse Practioner: To t	of examination	and/or invest	igation, in my opini	on, death o	ccurred at	the time, date ar	nd place, and d	ue to the c	cause(s) and manner stated.
within con the think the t		29b. Signature and title of certifier	lan		do	29c. Licens	e number	47	3	29d. Date sign	ed (Month	, Day, Year)
Stat		30. Name and address of person values that the state of t	adan, 1	death (Item	1130	OPAL	CI	- ;+	Jager	stown	η Δ	10 21740
Registra		JUL 9		·····	1	face						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26<sup>Day</sup> July 2011 2:47 PM Michael Eugene Mann Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 21 West Franklin St. Washington County Hagerstown Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-78-2972 1 X M 2 □ F Months Davs Hours Min. (Month 3 Pay, 1961 Mary Land 50 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location Director Maryland Washington County Hagerstown 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21742 U.S.A. 1330 Potomac Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Operating Room Tech. 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 all Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hy important: If item 27 is marked oth any injury or other them. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sylvia Smith Mann Robert Carl Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1150 Kenly Ave. Hagerstown, MD 21740 Sylvia S. Mann-mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 7-27-2011 4 Donation 5 Other (Specify) Smithsburg, Maryland 22. Name and Address of FacilityDouglas A. FIery Funeral Home Signature of Funeral Service Licensee 1331 Eastern Blvd. NorthHagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line. Approximate Interval Between Onset and Death nobable Immediate Cause (Final Ischemi Physician/ Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner oronary Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events asetes and-tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death
Unknown been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has performed certificate within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be WORK Place Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: To the Hospital or Attending Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kooup Dos 69606 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD KODUAH JW-4 St. #306, 21740 Antietan Hagerstown, 31. Date filed (Month, Day, Year) 32. R gistrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

11-05753 John Jesus Martin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onn Jesus Mar	un	State of 1- For State Registrar	Maryland / Depa Cea	artment of <i>rtificate of</i>		Mental H	ygiene Re	g. No. 201	1 25394
Physici Medical Exami		1. Decedent's Name (First, Middle,Last)					2. Date of Deat	h Dav Year	3. Time of Death 1025 hrs
	1161	4a. Facility Name (if not institution, give str			lb. City, Town, or Lo	ocation of Death	August 1,	2011 4c. County of D	
		8605 63rd Avenue			Berwyn Heigl			Prince Ged	
Funeral Director		5. Social Security Number 6. Sex 219-94-3192 1 🔀 M	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	_	) IF	Birthplace (State or or occupantly) Country)  Country)  Country
any		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Locati	on				10d. Inside City Limits
Maryland 28a-f show	ō	MD P.G.	Ве	rwyn He	ights				1 Yes 2 X No
Maryl	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
with the Maryland ns 23a nr 28a-f shu be notified at once.	a D	8605 63rd Avenue	. Was Decedent Ever in U.	S 13 Was	20740 Decedent of Hispa	anic Origin? ( So	ecify Yes or No-	USA	merican Indian, Black,
death v r item	une	1 X Never Married 2 Married	Armed Forces?		es, specify Cuban, N			White, et	tc.
s after or ral", o	by F	3 Widowed 4 Divorced If You	es, Give Year		Yes 2 No			Specify: Wh	
2 hours	eted	15. Decedent's Education (Specify only his Elementary/Secondary (0-12)	ghest grade completed) College (1-4 or 5+)		's Usual Occupation ost of working life. D			16b. Kind of Busine	ess/Industry
036 ithin 7 ene. or than Medica	Completed		4	Sound	Engineer	:		Electron	ics
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygione. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f shr injury or other traumatic event, the Medical Examiner must be notified at once	Be Co	17. Father's Name (First, Middle, Last)  John E. Martin			18		(First, Middle, M Galliz	laiden Surname)	
212 ould be I Menta I mark	To B	19a. Informant's Name/Relationship (Type,	Print )	19b. Mailing	Address (Street a			ber, City or Town, S	State, Zip Code)
MD 2 sho alth and m 27 is	Ì	John E. Martin/Fat						ghts, MD	
Baltimore, permit. Pages 1 at Department of Hec Important: If ite		20a. Method of Disposition  1 Burial 12 X Cremation 3	Removal from State	rematory or oth		A	Date	20c. Location - Cit	
it. Pagartment ortant:		4 Donation 5 Other Specify: 21. Signat f Funer I e ice ee	Met		an Cremat		2011	Alexandr	
Dem Dem Injury	1	Mary 7de		500	) Univers	ity Blve	d. W., S	Home In	c. ring, MD 20901
Physician /Medical		23a. Part I. Enter the disease, ir complicati failure. List only one cause on each li	™ Cardiac Ar	rhythmi	a due to	cardiac or	respiratory arre	st, shock, or heart r <b>ith</b>	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease a. Bi	ventricular to (or as a consequence of	Dilatat	ion				Death
		Sequentially list conditions, b							
	Examiner	if any, leading to immediate Due cause. Enter Underlying Cause (Disease or injury that initiated	to (or as a consequence of	·):					
and transit	Exal	events resulting in death) Last  Due	to (or as a consequence of	):					
60, te be execut ysician and burial - tran	ledical		nended 23a,27,p	er me,g	919 9-9-	ll sm			
760, ficate be g physicis the buri			Sc. If yes, outcome of pregr			]		23d. Date of deli	
OX 6876 eath certificate attending phy for use as the	iciar	past 12 months?	Pregnant at time of dea	ath -	al death 3 er (Specify)	Ectopic pregna	псу	Month	Day Year
D. Bo	Physician/N	1 Yes 2 No 9 Unknown 9  Part II. Other significant conditions con		sculting in the ur	derlying cause oive	on in Part I	23e Did tok	acco use contribut	e to the cause of death?
res that signed b	2	osi,	arbating to dodn't bat not re	outing in the ci	idonying cadas give	on an arty.	1 Yes		Probably 4 V Unknown
rds,	Completed						24a. Was ar		e autopsy findings available to completion of cause of
Reco	E	-					perform 1 🗸 Yes 2	ned? deat	h?
tal Recions: The certificate	Be	25. Was case referred to medical examiner?	al			Death (Check of			
of Vi	임	1 Yes 2 No	28a, Date of Injury	ER/Outpatient 28b. Time of In	J DON	- Table 11		Residence 6 🗸 O	ther: Scene
ion (fending eath.	틽	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day,Year)		1 Yes	2 No			
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho (Specify)	me, farm, street	, factory, office build	ding, etc.	28f. Location (St or Town, Sta		Rural Route Number, City
he Hospi in 24 hou he Funer pletely fil		29a. Certifier (Check only 1 Certifying Physician:	To the best of my knowledg						
To the within 2 To the complet	Medical		manner stated.		29c. License n		1	29d. Date signed (	
		Allen Brasse	( MI)		O.C.M.	E.		August 2, 201	1
	Ì	30. Nam and address of person who comp			Politimas C	not Daltim	- MD 24000		
St	ate		ant Medical Examin  32. Registrar's Signatu			et, Baitimor	e, MD 21223		
Regist	eir	31. Date filed (Month Day, Year) AUG 0 4 2011	32. Registrar's Signatu	. Mar	1				i

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Abdou1 Kader Ndiave 2011 July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Prince George Regional Laurel Laurei Social Security Number 9. Birthplace (State or Foreign Country) Bamako, Mal If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6 Sex 7. Age (In vrs. last birthday, **Funeral** 1 X M 2 □ F Days Min 4972.97 987 44 Director Mali 718-17-8255 Usual Residence of Decedent or 28a-f shov ntal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Md. Prince Georges Hyattsville 1 ☐ Yes 2 🖔 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 Funeral 3227 75th Ave., Apt#102 Mali Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces 1 Never Married 2 X Married þ Yes 2 X No within 72 hours after Baltimore, Maryland 21215-0036 black 1 Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Construction permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name *(First, Middle, Last)* Ibrahim Ndiaye 18. Mother's Name *(First, Middle, Malden Surname)* Kadidia Traore ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kadidia Traore/mother 75th Ave, Apt.102 Hyattsville, Md. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Family Cemetery 20c. Location - City or Town, State Date 7/29/11 Bamako, Mali 22. Name and Address of Facility Universal Mortuary 21. Signature of Funeral Service Licensee 411 Kennedy St NW Washington, DC 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Dear Immediate Cause (Final Physician/ erebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death g Unknown 9 Unknown P.O. signed by to d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pneumonia Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Seizure Disorder 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed? Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No ျှ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral! 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Tyes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier P D24721 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Syed A. Sadig, M.D. 14333 Laurel Bowie Rd, Suite 208

State Registrar

Syed A. Sadiq, M.D.

26 2011

20708

Laurel

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Madilyn Marie Osbo	1-For State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg.  I 2. Date of Death	No. 2011 25396					
Physician/ Medical Examiner	MADILYN MARIE	OSBORNE	Month D August 2, 20	Day Year 1414 hrs					
المر	4a. Facility Name (if not institution, give street and number) Union Hospital	4b. City, Town, or Location Elkton		4c. County of Death Cecil					
Funeral Director	664-62-9000 1 M 2 XF	e (In yrs. last birthday)  O Yrs.  If Under 1 Year If Under 1 Year If Under 20 Hour		(MM/DD/YYYY) 9. Birthplace (State or Foreign FLKTON Country) MARYLAND					
nu n	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits					
Maryland 28a-f show i 1 at once. ector	MARYLAND CECIL  10e. Street and Number	ELKTON		1 Yes 2 No					
the Maryland a or 28a-f sh otified at once	616 DEAVER ROAD	10f. Zip Code 21921	10g.	Citizen of What Country? UNITED STATES					
er death with , nr items 23 r. must be no	11. Marital Status  1 XX Never Married 2 Married Armed Forces?  1 Yes 2  3 Widowed 4 Divorced If Yes, Give Year	Ever in U.S.  13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexicar  1 Yes 2 No specify	n, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: LTHTTF					
6 72 hours after "natural" en Examine	15. Decedent's Education (Specify only highest grade com- Elementary/Secondary (0-12) College (1-4 or 5	pleted) 16a. Decedent's Usual Occupation (Give	kind of work done	6b. Kind of Business/Industry					
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other Manatural", ar items 23a or 28a-f sho injury ar other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	0 17. Father's Name (First, Middle, Last) KYLE M. OSBORNE	NEVER EMPLOYED	r's Name (First, Middle, Mai MORGAN CULV	•					
AD 21; 2 should b h and Mem 27 is marl matic eve	19a. Informant's Name/Relationship (Type, Print)  KYLEAM • OSBORNE / PARENTS	19b. Mailing Address (Street and Nur 616 DEAVER ROAD, I							
Baltimore, N permit. Pages I and Department of Healt Important: If item injury or uther trau	20a. Method of Disposition  1 XXBurial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:	20b. Place of Disposition (Name of cemetery,	AUGUST 6,	20c. Location - City or Town, State  NORTH EAST, MARYLAND					
Baltir permit. F Departme Importar	21. Signature of Funeral Service Licensee	22. Name and Address of Facilit 127 SOUTH MAIN	CROUCH FUNER	RAL HOME, P.A. TH EAST, MARYLAND21901					
Physician Medical Examiner	23a. Part I. Enter the disease, or complications that caused failure. List only one cause in each line. Cardia Immediate Cause (Final disease or condition resulting in death)  a. Calcification Due to (or as a conse	the death. Do not enter the mode of dying, such as o i.c arrhythmia due to art ation of infancy	cardiac or respiratory arrest cerial medial	, shock, or heart Approximate Interval Between Onset and Death					
50, te be executed spision and burial transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
60, tte be executed hysician and e burial - transit	d.  X UNPENDED AMENDED 23a, 27, per me, g918 8-11-11 sm								
). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transi Physician/Medical E.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Unknown  23c. If yes, outcom 1  Live birth 4  Pregnant at 12 Unknown		c pregnancy	23d. Date of delivery Month Day Year					
P.O. It es that the iigned by the detached	Part II. Other significant conditions contributing to death	out not resulting in the underlying cause given in Pe		cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown					
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the ledical Certification: To Be Completed by Physician/N			24a. Was an autopsy performe						
fital sicinus is certificector.	25. Was case referred to medical examiner?  Hospital:   Inpatie	26.Place of Death  nt 2 ✓ ER/Outpatient 3 DOA Other	, ,	sidence 6 Other:					
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. Completely filled in by the funeral director. edical Certification: To Be (	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injun (Month, Day,Ya		(? 28d. Describe how						
Division o  To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral ledical Certification:	4 Homicide Homicide (Specify)	ury - At home, farm, street, factory, office building, e	tc. 28f. Location (Stre or Town, State	eet and Number or Rural Route Number, City e)					
To the Hosp within 24 ho To the Fune completely f	29a. Certifier (Check only one) 2  Medical Examiner: On the basis of examiner and manner stated.	knowledge, death occurred at the time, date and plaination and/or investigation, in my opinion, death oc	ace, and due to the cause(s courred at the time, date and	s) and manner as stated d place, and due to the cause(s)					
M A S H S M	29b. Signature and title of certifier	29c. License number O.C.M.E.		9d. Date signed <i>(Month, Day</i> , Year) August 3, 2011					
	30. Name and address of person who completed cause of de Pamela E. Southall, MD Assistant Medie	eath (Item 23a) cal Examiner 900 W. Baltimore Street	t, Baltimore, MD 212	23					
State Registrar	31. Date filed (Month, Day, Year) AUG 0 9 2011 32. Poistrar	s Signature parks							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	artment of Health and I	Mental Hygiene						
I	Physicia Medic		Decedent's Name (First, Middle, Last)     CHARLES CHURL OH		2. Date of Death	3. Time of Death 0138 A M					
ا مورود	Examir		4a. Facility Name (if not institution, give street and number) HOLY CROSS HOSPITAL	4b. City, Town, or Location of Death SILVER SPRING							
Ī	Funeral Director		5. Social Security Number 206 46 3264 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth 08/20/1927	9. Birthplace (State or Foreign Country) Korea					
	aryland a-f show ified at	Director	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Lo		<u> </u>	10d. Inside City Limits 1 ☐ Yes 2 🎇 No					
	with the M 23a or 28 ist be not			10f. Zip Code 20902	10g. Ci	tizen of What Country?					
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	1 Nover Married 2 Married Amed Forces	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: ASIAN					
Baltimore, Maryland 21215-0036	within 72 hou giene. er than "natu the Medica	Completed	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	dent's Usual Occupation kind of work done during most of wor O NOT use retired) rietor	king	Cind of Business Industry					
yland	id be filed Mental Hyg arked other atic event,	17. Father's Name (First, Middle, Last) Hae Kwan Oh  18. Mother's Name (First, Middle, Maiden Surname, Soon Hee Kim									
, Mar	nd 2 shoul ealth and m 27 is m		William B. Oh (Son) 2206	ng Address (Street and Number or Ru Westmoreland St/							
timore	Page 1 a tment of H tant: If ite jury or ott		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition State  Mt Comform	matory or other place)		ocation - City or Town, State exandria VA					
Bal	Depar Impor any in		Ac Ac	2. Name and Address of Facility  dvent Funeral Serv		Lee Hwy Church VA 22046					
يميد	Physician/ Medical Examiner	er	23a. Part 1. Enter the disease of complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sepsis  Due to (or as a consequence of):  Respiratory Failures of any, leading to immediate but the conditions, if any, leading to immediate		or respiratory arrest,	Approximate Interval Between Onset and Death					
.09	aath certificate be executed attending physician and for use as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlyin. Cause (Disease or iinjury that initiated events resulting in death) Last  Due to (or as a consequence of):  Pneumonia  Due to (or as a consequence of):  Bilateral Pleural  d.	Effusion							
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Pregnant at time of death 5 Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year					
ls, P.C	uires that to signed build be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		use contribute to the cause of death?					
Division of Vital Records, P.O.	sician: The law requ certificate has bee irector, page 2 shou	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No					
Viita	ysician: is certific director,	To Be (	25. Was case referred to medical examiner?  1  Yes 2 X No  Hospital: 1 X Inpatient 2  ER/Outpatie	26. Place of Death (Chec	_						
on of	ending Ph eath. or. After th he funeral	y occurred									
28d. Date of injury of injury at work?  1 X Natural 5 Pending Investigation 3 Suicide 4 Homicide Homicide determined 1 Sec. (Specify)  28d. Date of injury at work?  1 Yes 2 No  28d. Injury at work?  1 Yes 2 No  28d. Describe how injury occurred work?											
	the Hosp hin 24 hor the Fune mpleted fi	Medical	29a. Certifier (Check only one)  1	tigation, in my opinion, death occurred a death occurred at the time, date and pla	at the time, date and place ace, and due to the cause(s	e, and due to the cause(s) and manner stated. s) and manner as stated.					
D	5 V V I		29b. Signature and title of certifier  Pahmania	29c. License number D66372		te signed (Month, Day, Year) 07/25/2011					
_	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Final Majid Rahmanian, 1500 Forest Glen Ro	,	, MD 20910						
	Stat Registra	e ir	31. Date filed (Month, Day, Year)  JUL 2 7 2011  Server B. Sarks								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Regis <b>Ame</b> n	d #30, 7	State of M / <b>26/2011</b> ,					nd Mental Hy	/gien Reg. N	2011	2	5398
	Physicia	n/	1. Decedent's Nam	e (First, Middle, La	ist)					2. Date of D	eath			ne of Death
	Medic	cal		J. Olan	e street and number)		. 1	4h City Tours on	Location of	July	23	3 201 c. County of De		<u>Mq 0</u>
	Examin	ier		ford Plac				4b. City, Town, or	lumbia		4	Howard	_	
	Funeral		5. Social Security N	umber 6.		e (In yrs. las		If Under 1 Year Months Days	If Under 2			9. B	irthplace (St	ate or Foreign
	Director		219-12-4 Usual Residence of	1495	I E F W Z L F	92	Yrs.	mentile = sy		Min. 12/07	7191	L8		MD
	show dat	tor	10a. State	10b. County		10c. City,	Town or Loc	ation						de City Limits
	Mary 28a-f lotifie	Director	MD	Howa	rd		Colum							Yes 📉 No
	ith the	ral D	10e. Street and Nur		10			10f. Zip Code 2104	4		10g. C	Citizen of What C United		s
	eath w	To be a specific Cuban Mexican Puerto Bigan etc.)  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes specify Cuban Mexican Puerto Bigan etc.)  14. Race									14. Race - An	- American Indian,		
030	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Marı 3 ☐ Widowed	ried 2 🔀 Married 4 🗌 Divorced	Armed Forces?  1   Yes 2   If Yes, Give  Year or Dates.	No		Yes, specify Cuba  Yes 2 X No		Puerto Rican, etc.)		Black, White, etc. Specify: White		
<del>ر</del>	2 hour "natu adical	plet	(Spe	15. Decedent's ecify only highest g			(Give k	ent's Usual Occupa	ation Juring most o	of working	16b.	Kind of Busines	s Industry	
121	ithin 7 ene. r than	Completed	Elementary/Sec 12	onday (0-12)	College (1-4 or	ō+)		NOT use retired) Ite Sales	man		G	reenspri	ing Da	irv
טַ	filed wall Hyg	Be	17. Father's Name						18. Mother	's Name (First, Middle	, Maider			
<u>a</u>	S should be file th and Mental F 7 is marked o traumatic eve	₽		E. Olan						hel R. Hol				
	12 shou lith and 27 is n r traum	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 50.2 Elaine Everhart – daughter 5004 Lake Circle Columbia, MD 21044											Zip Code)	
ď.	of Heal of Heal fitem		20a. Method of Dis	position	☐ Removal from State	20b. Pla	ace of Dispos	sition (Name of		Date	т —	Location - City	or Town, Sta	te
Ĕ	. Page ment tant: I			5 Cremation 3 L		cemetery, crematory or other place)  Lake View Memorial 07/27/2011 Sykesv.						Sykesvil	lle, M	D
Ball	permit. Page 1 Department of Important: If i any Injury or o	0	21. Sign fre of Fu	( ) ( )	Romar		- 4	Name and Address		Harry H. ia Pike El	Witz lico	zke's Fa	emily , MD	F.H.Inc. 21043
	nysician/		shock, or hea Immediate Cause	rt failure. List only (Final	nplications that cause one cause on each lin	d the death e.	Λ		g, such as ca	ardiac or respiratory a	arrest,		Onset	l Between and Death
	Medical resulting in death)  a. Lie to (or as a consequence of):												104	nontus
Examiner  Sequentially list conditions, b. Pulmonary Embolism									1/15	1/2011				
	red	Examine	if any, leading to in cause. Enter Unde Cause (Disease or	erlying linjury	Diah	a consequi	ence of):						10 %	lears
	execui an and rial-tra	I Exa	that initiated event resulting in death)	s	Due to (or as	a conseque	ence of):						1	
3	icate be executed physician and s the burial-transit	edical			d								-	
λ Ω	certifica Iding p		IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome							23d, Date of o	delivery	
POX	the atter	Physician/M	in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months?	1			Ectopic pregnand Other (specify)	у			Month	Day	Year
т. О	es that th signed by be detac	by	Part II. Other signi	ficant conditions	contributing to death t	out not resu	Iting in the ur	nderlying cause giv	en in Part I.			use contribute		e of death?
SDC	requir been s should	letec								24a. Wa		-		ings available
Vital Records,	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Completed								aut	opsy formed?	death'		o
Ta	siclar s certif	To Be	25. Was case referrexaminer?	No	Hospital:	ient 2 🗆 E	ER/Outpatien	Othe		sing Home 5 Res	idanaa	6 Other /Pa	ooifu)	
6	ng Phy ter this neral c		27. May er of Deat	_	28a. Date of inju	iry :	28b. Time of injury	28c. Injury	at	28d. Describe			ecity)	
0	tendir Jeath. Ior: Af the fu	Certificate:	1 Natural 2 Accident 3 Suicide	5 ☐ Pending Investigation 6 ☐ Could not	on he			M 1 🗆	Yes 2 🗆 N					
DIVISION	al or At s after o l Direct d in by	9 1 10	4  Homicide	determined		ury - At hor c. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location City or To		ind Number or F te)	Rural Route I	Vumber,
_	Hospita 24 hours Funeral eted fille	Medical	(Check 2	🔲 Medical Exan	ysician: To the best of	examination	and/or investi	gation, in my opinio	n, death occ	curred at the time, date	and plac	ce, and due to th	e cause(s) ar	nd manner stated.
	To the within To the compl	Σ	only one) 3 29b. Signature and		rse Practioner: To the	best of thy	C)	29c. License		and place, and due to		Pate signed (Mor		ar)
			1/2	Simol	(atale	me	XVO	1100		18.	Julg	1/26/	201	/
	<b>S</b> †		5450	Knoll N	completed cause of corth Dri	leath (Item	23a) (Type, Pi	erint) Boni 2 250	01	latalano, umb in	77	no 2	1045	_
	Stat Registra		31. Date filed (Mont	JUL 2 6 2	011 32 Registr	ar's Signatu	A. Spa	aked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25399 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 620 AM Physician/ Month 07 Year David Leo ORNDORFF 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 20019 Sheridan Avenue Hagerstown Washington If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F June 15,1934 **Director** 77 Maryland 217-28-5323 Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington 1 Yes 2 X No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20019 Sheridan Avenue 21742 USA alth and Mental Hygiene.
alth and Mental Hygiene.
a 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ No
If Yes, Give
Year or Dates. 1956-1958 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) power plant Elementary/Seconday (0-12) College (1-4 or 5+) Ft. Detrick electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clyde R. Orndorff Beulah Mae Halley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trans Rebecca Orndorff - daughter 9715 Deanewood Lane, Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Union Cemetery Lovettsville, Va. 7/30/11 Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 2 COULT 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Pulmonary F Due to (or as a consequence of): Onset and Death Physician/ disease or condition resulting in death) Years Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause injury Due to (or as a consequence of) that initiated events physician ar resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Day the ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Completed Chronic Obstructive Pulmonary 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an or Attending Physician: The law page 2 s autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: ပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

S-MC

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Burbaver A. Spencer, CRNP 747 North

32. Registrar's Signature

31. Date filed (Month, Day, Year)

K115203

747 Northern Avenue Hagerstown, MD 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25400 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July Day Elizabeth K. Oppenheim 2011 11:36aM Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 9. Birthplace (State or Foreign Country) Wis Consin 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Days Months 393-34-9885 0977371935 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Rockville 1 Yes 2 X No Maryland Montgomery 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5809 Nicholson Lane, 20852 #809 U.S.A. hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ō 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify White 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Manager Journal of Biochemistry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Jack Kaner Mae Frumes permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joost Oppenheim - Husband 5809 Nicholson Lane. #809, Rockville, Maryland20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grdns:07/24/2011 4 ☐ Donation 5 ☐ Other (Specify) Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Signature of Funeral Service Lic 11800 New Hampshire Ave., Silver Spring, MD 20904 C 23a. Part 1. Enter the dise shock, or heart failur complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Interstitial Lung Disease disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Rheumatoid Arthritis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and s the burial transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ Septic Shock Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? Pulmonary Hypertension 24a. Was an page 2 autopsy performed? Yes 2 X No this certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗆 Yes 2 🗓 No Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical

State Registrar

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

Siddharth Bethi.

31. Date filed (Month, Day, Year) **JUL 25 2011** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Registrar's Signature

🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6

8600 Old Georgetown Road, Bethesda, Maryland 20814

29d. Date signed (Month, Day, Year)

July 21. 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien = State Registraf MEND#23aI+IIperMD,7/26/11, HW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Deborah Bradley Oberholtzer 4:30 P. M Medical 2011 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Montgomery North Bethesda Brighton Gardens of Tuckerman Lane . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
DeC 26, 1927 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** Months Hours 201-22-7623 **Director** 83 Pennsylvania Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD North Bethesda Montgomery 1 X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 5550 Tuckerman Lane 20852 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. jo. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3X Widowed 4 ☐ Divorced "natural", Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Scully Bradley Margurite Cashner and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Jeannette W. Lingelbach/Daughter 9 Hilltop Road, Silver Spring, mD 20910 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 21 2011 1 Burial 2 Cremation 3 Removal from State Georgetown university Washington, D.C. 4 X Donation 5 ☐ Other (Specify) Medical Center 22. Name and Address of Facility Columbia Mortuary Services, F.A. Signature of uneral Service /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition a Dementia Medical resulting in death) Due to (or as a consequence of) **Examiner** Dys hagia Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Tis Time Hypertension Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events . Aspiration and Arthritis. resulting in death) Last attending physician a for use as the burial-Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached i Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure to thrive 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown has been sign e 2 should b Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed? Yes 2 X No death? certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2**X** No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other Specify After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No 1X Natural 5 Pending M 2 Accident
3 Suicide
4 Homicide Accident Investigation within 24 hours after death

To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D53691 July 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3200 Tower Oaks Blvd. Suite 110 Ajay Reddy, M.D. Rockville, MD 20852 31. Date filed (Month, Day, Year) Registrar's Signature ball State JUL 25 2011 Registrar

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25403 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ 26 P M 3:45 Lois Lee Palmer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 54 Winter St Hagerstown Washington 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. Days 1 □ M 2 🛣 F Months Hours (Month, Day, Year 213-24-9626 Director March Hagerstown MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 21740 54 Winter St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 9th College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Francis Elizabeth Davis George William Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Howard E. Palmer, Jr.</u> /Husband 54 Winter Street, Hagerstown <u>MD 21740</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rose Hill Cemetery 07/29/2011 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause oη each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Canca Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year ☐ Pregnant at time of death ☐ Unknown 5 Other (specify) P.O. I signed by the Part II. **Other significant conditio**ns con<u>tribut</u>ing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? 5 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page 2 s cardiane this certificate 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home \(\frac{\pmax}{2}\) Residence \(6 \sum \) Other (Specify) No. ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 144 Natural 5  $\square$  Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse/Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numb 29d. Date signed (Month, Day, Year) 30, Name and address of person woo completed cause of death (Item 23a) (Type, Print) JW-5

Registrar DHMH 17 Rev 7/2009

State

Smo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ 24, 2011 8:30 A M Alan Poper Larry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 220 West Franklin Street Hagerstown 9. Birthplace (State or Foreign Country) Maryland Age (In vrs. last birthday) ear If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ₹ M 2 □ F Days Months Hours Min. (Month, Day, Year 217-56-2166 60 Director 10.1951 Hebruary Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 No Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 220 West Franklin Street 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 XYes 2 If Yes, Give Black, White, etc 1 Never Married 2 Married by 72 hours after 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Je filed witr... \*∗al Hygiene. \*••r than "p Elementary/Seconday (0-12) College (1-4 or 5+) Not Applicable Disabled permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Edward Poper Mildred Louise Summers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald E. Poper Brother 304 North Preston Street, Charles Town, W.Va. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hagerstown Crematory 07-25-11 4 Donation 5 Other (Specify) |Hagerstown, Maryland 21. Signature of Funeral Service License Andrew K. Collman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, K. hoel Brad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ orman Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: . use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 5 Residence 6 Other (Specify) 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending after death.

Director: Aft Accident
Suicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined completed filled in by City or Town, State within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, D)

JW +1

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

MD

**ORIGINAL** 

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			4 00	artment of Health and Me		ene .g. No 2011	25406
	Physicia		Decedent's Name (First, Middle, Last)     CHARLES REDDING		2. Date of Death Month		3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)  Manor Care Largo	4b. City, Town, or Location of Death Largo	uı	4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 87 Yrs.	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth (Month, Day, )	9. Bir	thplace (State or Foreign untry)  NC
	yland •f show ed at	ctor	Usual Residence of Decedent  10a. State  10b. County  MD Prince George's Mitche	cation			10d. Inside City Limits
	ith the Mar 23a or 28a st be notifi	Funeral Director	10e. Street and Number 3601 Aynor Drive	10f. Zip Code 20721	10	Og. Citizen of What Co	1 🗆 Yes 2 🇖 No puntry?
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 Myes 2 No	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ame Black, White Specify:	
Congestive Haart Parlure Baltimore, Maryland 21215-0036	within 72 hour giene. er than "natu , the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Flementary/Seconday (0-12)  College (1-4 or 5+)	dent's Usual Occupation kind of work done during most of working O NOT use retired) il Clerk	Y Z	leb. Kind of Business Veterans Administr	Industry
land	d be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Bud Redding	18. Mother's Name (F Anni	First, Middle, Ma Le Hari	aiden Surname) CİS	
Ne h	nd 2 shoul salth and I n 27 is mi er trauma		19a. Informant's Name/Relationship (Type, Print) Charles Redding, Jr son 360	ng Address (Street and Number or Rural R l Aynor Dr Mitc	Route Number, C chellev	City or Town, State, Zip Ville MD	20721
<i>Mestr</i> imore,	Page 1 ar ment of He tant: If iter ury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition Commeterly, oper Arlington	osition (Name of Dat natory or other place) On Nath unkno		20c. Location - City or Arlingto	
Balt	permit Depart Import any inj		Neln E Scruf 8:	2. Name and Address of Facility Gre 14 Franklin St	Alexa	andria V <i>I</i>	ome Inc A 22314
Sp	Ph <sub>y</sub> sician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one hause on each line.  Immediate Cause (Final disease or condition on the condition of t	er the mode of dying, such as cardiac or re Heart Failur	respiratory arres	ıt,	Approximate Interval Between Onset and Death
	Medical Examiner	بيد	Hypertensio				
	cuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Cer			
09	ate be executed hysician and the burial-transit	dical	resulting in death) Last  Due to (or as a consequence of):  d.				
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Ectopic pregnancy Other (specify)		23d, Date of de Month	livery Day Year
ds, P.O.	luires that the signed by all be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the under the conditions and the conditions contributing to death but not resulting in the conditions.	nderlying cause given in Part I.		acco use contribute to	the cause of death?
Division of Vital Records,	:: The law rec icate has bee r, page 2 sho	Completed			24a. Was an autopsy perform	prior to	topsy findings available completion of cause of
Cancer Vital Re	ysician is certif director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No 1 Inpatient 2 ER/Outpatien	26. Place of Death (Check or		nce 6 Other (Spec	:ifv)
of of	inding Phath.	Certificate:	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) injury			v injury occurred	
ا Sivisi Sisio	ral or Atters after de al Directo		3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, strubuliding, etc. (Specify)	eet, factory, office 28	Bf. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	he Hospii in 24 hou: he Funeri pleted fill	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death of the control of t	tigation, in my opinion, death occurred at the	ne time, date and	place, and due to the	cause(s) and manner stated.
	To t To t Con		29b. Signature and title of certifie	29c. License number D - 51520		Pd. Date signed (Montion $7 - 26 - 2$	
ואיז	_3		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print) AS GINGTON, DC	200	32	
	Star Registra		31. Date filed (Month, Day, Year)  JUL 2 7 2011  Server 6. Sparks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jesse Theodore Roach Month 07/21 2011 6:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 5851 Stephen Reid Road Calvert Huntingtown Social Security Numbe . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F (Month, Day, Year) 06/11/1942 Country) Director 69 429-72-4562 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland al Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏝 No MD Huntingtown Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20639 5851 Stephen Reid Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White Completed other traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland Maryland marked other than Elementary/Seconday (0-12) College (1-4 or 5+) State Police State Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o Jesse T. ROach, Sr. Ollie Hamlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1750 Lottie Fowler, Prince Frederick, MD 20678 Daren Roach / Son Important: If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Miranda Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 07/28/2011 | Huntingtown, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Edrys Godf 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COMMO disease. Physician/ disease or condition resulting in death) Medical Due to (or as a consecu a ce of): Examiner ertension Sequentially list conditions Examiner cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Dav Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed of Veg 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5 K Residence 6  $\square$  Other (Specify) ြု 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after deau.

To the Funeral Director: After this ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20060638 Mendone

ARW 10 State

Registrar
DHMH 17 Rev 7/2009

Hospital

Ste 310 Prince Frederick MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

endonga

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 7/22/2011 Day Norman Irving Rosenblum 7:07 a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing Center Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 3/18/26 Months 125-14-1280 85 Director Usual Residence of Decedent 28a-f show 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No DC Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral items 23a 2127 California St. N.W. apt. 20008 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Ves 2 No
If Yes, Give WWII
Year or Dates Black, White, etc. "natural", or δ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 3 X Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Many injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) Engineer <u>Aerospace</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathan Rosenblum Bertha Nemser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renay Tucker-Daughter 2127 California St. N.W. apt 704 Washington 20008 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Judean Memorial Gardens 7/25/11 Olney, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky Goldberg 1170 Rockville Pike Rockville, Md. 20852 M00910 Rockville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardio Pulmonary Arrest Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transit death certificate be executed <u>Multi Labor</u> Pneumonia that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End Stage Dementia Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Failure to Thrive 24a. Was an cate has page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending 1 X Natural To the Hospital or Attendir within 24 hours after death, To the Funeral Director: Af 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marichu Matas 10110 Molecular Dr. Suite 2 Rockville, Md. 20850

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) **JUL 25 2011** 

Box 68760

P.O.

Division of Vital

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20<sup>Pay</sup> 201 Year July Gerald Raine 8:24 A Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** Suburban Hospital Montgomery Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours Min 1**X**□ M 2 □ F Jan. 123 Year 1933 Washington DC 78 Director 577-42-3968 Usual Residence of Decedent rral", or items 23a or 28a-f shov Examiner must be notified at 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Rockville MD Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5809 Nicholson Lane, Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: White Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important if flem 27 is marked other than any injury or other trainment. Elementary/Seconday (0-12) College (1-4 or 5+ Buisness Owner Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward J. Raine Fannie Ash 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Raine/Son 43706 Burning Sands Terrace, Leesburg, Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
King David
Memorial Gardens 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/22/2011 Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of FacilDanzansky-Goldberg Memorial Chapel mo1597 Mcgneenhud 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory rrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onser and Death Immediate Cause (Final Physician/ Subdural Hemorrhage disease or condition. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease Or impuly that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy The law requires that the death in the past 12 months? Day Month Year Pregnant at time of death
Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Leukemia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 2 🗌 No Yes 2 😾 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 LXYes 2 □ No Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes neral Director: A l filled in by the fi 2 X Accident 7/19/2011 8:00 2 🙀 No Investigation Fall 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 20852 3898 Nicholson In; Rockville, MD 4 Homicide home within 24 hours a

To the Funeral D

gompleted filled Medical

State Registrar

29a. Certifier (Check

29b. Signature and title of certifier

31. Date filed (Month Da

Doen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011 082

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decal.

Raine;

m D

Steven Wilks, 8600 Old Georgetown Road, Bethesda, Maryland 20814

Registrar's Signaty

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0063195

July 20, 2011

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State of Marylar Registrar	nd / Department o Certificate o			2011	25410	
Physician	Decedent's Name (First, Middle, Last)     MARY TIMKO STIGILE			2. Date of Death Month JULY 29	Day 2011 Year	3. Time of Death 7:58 p <sup>M</sup>	
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 371 W. Main St.	4b. City, Tow Elkt	n, or Location of Death		4c. County of Death	n	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. 222–03–8414 1 M 2 X F 93		ar If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Birti	nplace (State or Foreign untry) Laware	
Director	Usual Residence of Decedent	ty, Town or Location		Dec 3 13	17 DC.	10d. Inside City Limits	
a-f short		Lkton				1 XYes 2 No	
3a or 28	10e. Street and Number 371 W. Main St.	10f. Zip Coo 2192			. Citizen of What Co	untry?	
irs after death with the Mar irs, or teems 23a or 28a-f si confiner must be notified by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	.S. 13. Was Decedent If Yes, specify (	of Hispanic Origin? (Sp uban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Department of Heatin and Mental Hygiene. Department of Heatin and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Erroninar must be notified at once.  To Be Completed by Funeral Director	(Specify only highest grade completed)  Elementary/Secondary (0-12)  R	16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re Homemake	ne during most of work tired)	ing	16b. Kind of Business/Industry Own Home		
ylailu A vuld be filed Mental Hygi arked other atic event, I	17. Father's Name (First, Middle, Last) Michael Timko	110.11.01.12		e (First, Middle, Ma			
INICAL Y  nd 2 shoul alth and M  27 is mar r traumati	19a. Informant's Name/Relationship (Type. Print)  Lorraine Barlow (daughter)	19b. Mailing Address (Str. 371 W. Mair.		al Route Number, C	•	Zip Code)	
Pages 1 and the substitution of the substituti	★ Purial 2 Cromotion 2 Demoval from State	Place of Disposition (Name o cemetery, crematory or other nester Cemeter	place)		c. Location - City or Chestertov		
Definit. Departit Importa any inju	21. Sign rure of Fineral State Licensee  M00510	22. Name and Ac Galena F 118 W. C	dress of Facility Uneral Home Pross St. G	e of Step alena, MD	hen L. Sch . 21635	naech	
Physician /	23a. Rart . Enter the disease, or complications that caused the dear shock, or leart failure. List only one cause on each line.  Immediate C is e (Final disease or o'ndition resulting is death)  Due to (or as a consec	st Cancer	dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death	
Examiner		· · · · · · · · · · · · · · · · · · ·					
por DO, icate be executed physician and the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consect of the consect of						
ertificate being physicials as the bur	d						
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after decent. The attending the attending to the Fundamental Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnant at time at time a	al death 3 🗌 Ectopic pregr			23d. Date of del Month	ivery Day Year	
quires that quires that an signed to uld be dete	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause	given in Part I.			the cause of death?	
: The law requir				24a. Was an autopsy performe 1 □ Yes 2	d2 prior to death?	ntopsy findings available completion of cause of	
ysician is certifi director,	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2	] ER/Outpatient 3 □ DOA	O++	h <i>(Check only one)</i> ome 5 <b>⊠</b> Residen	ce 6 ☐ Other (Spe	cify)	
ding Phy th. After thi funeral c	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	Injury	njury at Work? 1 □ Yes 2 □ No	28d. Describe how			
tal or Attending Fragility at Director: After led in by the funering Certification:	2 □ Puiside 6 □ Could not be	lome, farm, street, factory, offi fy)	ce	28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,	
o the Hospita Ithin 24 hours o the Funeral ompletely filled	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kn (Check only one)  1 Medical Examiner: On the basis of examinand manner stated.	owledge, death occurred at the ation and/or investigation, in	ne time, date and place my opinion, death occur	, and due to the cau red at the time, dat	ise(s) and manner as e and place, and due	s stated.  to the cause(s)	
To th within To th comp	29b. Signature and title of confier  Jachdev 5 mb	(1, 1)	cense number 0023322		Date signed (Mont)	h, Day, Year) &o]].	
	30. Name and address of person who completed cause of death (Iter S.S SACHDEV MD 126A,	m 23a) (Type, Print)  E High ST, ature	E Cklon	MD 2192	/.		
State Registrar	31. Date filed (Month, Day, Year) 32 Augustrar's Sign	A Barle					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2011  $a^{M}$ CATHERINE Μ. STATES JULY 30 2:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Chester River Manor Chestertown Kent 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 X F Director 213-44-1027 80 Sept 1 1930 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Modified Leaving or other traumatic event, the Modified Leaving to the standard or other traumatic event, the Modified Leaving to the standard or other traumatic event, the Modified Leaving to the standard or other traumatic event, the Modified Leaving to the standard or other transfer or oth MD 1 XYes 2 □ No Director Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 Morgnec Rd. Apt. 3 D 21620 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 🔣 No White þ Specify: Specify: 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aid Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If item 27 is marked of Henry Kemp Ida Mae Walls ္ဝ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger States (son) Crumpton, MD. 21628 P.O. Box 245 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Chester Cemetery 8/2/11 Chestertown, MD. 4 ☐ Donation 5 ☐ Other (Specify) - Ingeral Service Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 any M00510 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1. Enter the Immediate au (Final disease or contion resulting in death) **Physician** ESTRATORY /Medical Due to ( as a consequence ) Examiner Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed ADVANCED COPD WITE O, and burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for L Day in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2♥No P.0. the 9 I Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No the Hospital or Attending Physician: The At Stary C > Co 25. Was case of rred to medical examiner? certificate or Cardrac 2 No Division of Vital 1 Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1 A Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖻 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

JOHN C. ARRABALTK, U.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 9 2011 Serve S. park

123889

223 High Street, CHaster Foun Wed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Statemend #30, 7/26/2011, per HCHD/DYRicate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jac Month 3. Time of Death Physician/ Martha 1958 M 2011 schravesande 24 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Loundy Genera 1-loward H051111 Columbia Social Security Number If Under 1 Year I If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F 414 08 1471 Country Wash DC Min. 0672071943 **Director** 68 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Laurel 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 15705 Bond Mill Road 20707 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14 Race - American Indian Armed Forces Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Completed by 1 X Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled NΆ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John B. Schravesande Marian Florine Storrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arc Nasasha Parker - Representative 11735 Homewood Road Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any injury or ot Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Crematory 07/26/2011 Hanover, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph\_sician Houns disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events burial-tran and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregrant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death the 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🖪 No Hospital ပ္ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending infurv 1 Yes 2 No

Baltimore, Maryland 21215-0036 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 Division of Vital Records, 24 hours after deaun.

• Funeral Director: After this ( Certificate: Accident Investigation 2 Accider
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MY 142892 Jul 2011 Francis S. Chuidian, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 MP 21044 Calumbia eaistrar's Signature State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23 2011 1450 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12818 Beechtree Lane Prince George's Bowie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 26, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 - M 2 F Country)
rginia 579-36-0803 84 Director Yrs. May 1927 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director 1X Yes 2 ☐ No MD Prince George's Bowie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 12818 Beechtree Lane 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after obpartment of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur L. Walker Leola Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Walker / Nephew 12818 Beechtree Lane, Bowie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State injury or Metro Crematory 4 Donation 5 Other (Specify) 7/21/2011 Baltimore, MD 21. Signature of Funeral Service bicensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 art 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between net nd Dem Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery in the past 12 month 3 Ctopic pregnancy
5 Other (specify) Month Day Pregnant at time of death signed by the a d be detached f Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performe death? this certificate 2 No Yes 25 director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 700 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA upleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at After t Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 No Accident Investigation after death Director: / 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10

Registrar
DHMH 17 Rev 7/2009

State

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 24 2011 4:41 РМ Gertrude Sugden Anna /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Director Pennsylvania 172-14-9908 90 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ed other than "natural", or items 23a or 28a-f shovevent, it is the discipled at 1 □Yes 2 No Director Calvert Owings 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code **USA** by Funeral 1116 Ontario Court 20736 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ould be filed within 1 Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any Injury or other traumatic ev Salada Homer В. Effie Waggett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert L. Sugden, spouse 1116 Ontario Court. Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithville Cemetery 07-28-2011 Dunkirk, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. Illiam R 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Immediate Cause (Final disease or condition resulting in death) neumonia **Physician** /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ementia be executed and burial-trar signed by the attending physician المامة عمله O. Box 68760 Physician/Medical The law requires that the death certificate IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 - Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknow ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed peen a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy this certificate 1 ☐ Yes 1 ☐ Yes Vital Hospital or Attending Physician: .25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 Mo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ of 27. Manner of Deatl 28a . Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No d in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide ie Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) the 29b. Signature a 29d. Date signed (Month, Day, Year) 29c. License number o ddress of pers cause of death (Item 23a) (Type, P Road; Prince DRW 15

State Registrar homas

31. Date filed (Month, Day, Year,

JUL

32: Registra Si

For State of Maryland / Department of Health and Mental Hygiene 23aPtI, II per dr. 2920, 10/11/2011dhb
Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carolyn Sue Simms Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Washington Hagerstown Social Security Number If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. Year 1 🗆 M 2 😾 (Month, Day, 21/42 Country) Director 69 299-46-0167 VA Usual Residence of Decedent shov 10a State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified 28a-f 1 1/2 Yes 2 🗀 No VA Loudoun Purcellville 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? pe ritems 25. 23a by Funeral 112 Locust Grove Drive 20132 filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or iter Examiner 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes Give Specify: White "natural", 3 Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home t. Page 1 and 2 should be filed with thrent of Health and Mental Hygien rtant; if item 27 is marked other 1 jury or other traumatic event, 也 other Homemake Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Alfred Staunton Nelson Julia Grubbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig Simms (Son) Locust Brove Dr. Purcellville, Va. 20132 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department or Important; If any injury or X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pineview Cemetery! 8/1/2011 Orgas, WV 22. Name and Address of Facility Armstrong Funeral Home, INC. 21. Signature of Funeral Service Licer 1001035 Box185 Whitesville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Sepsis Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Probable Infarcted Intestine **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Dub to (or as a consequence of) burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) ing physician a Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown attendi use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ξ Month Day signed by the a 9 Unknown P.O. II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyperlipidemia, Gastro Esophageal Reflux Disease 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown page 2 should Alzheimers Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 Tes ial or Attending Physician: The safter death.

In Director: After this certificated in by the funeral director, pages and in by the funeral director, pages. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 410 Other: 욘 1 Yes 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Funeral 24 hours Medical 29a. Certifier 🕒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1-13 MD D (8019 JULY 29, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAKERLADWY MO スイフリッ 57 JW - 5 DATTA W 10 3 no mile 31. Date filed (Month, Day, Year, State 32. Re Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** 50 AM 26,2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner la:a town Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** Days 1 Ø M 2 □ F 212-24-6232 83 Director May 1. 1928 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f shov 1 □Yes 2 🙀 No Director Maryland Washington Co. Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Evania MELINIAS Denomes. 1140 Luther Drive 21740 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1**X** Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2√√ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk/Typist State Prison System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Isaac Shank ည Anna Hazel Gladhill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Shank / Wife 1140 Luther Drive, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery July 28,2011 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21 Signature of Funeral Service Licensee Jaurlos 1331 Eastern Blvd. N., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mires **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year 5 ☐ Other (specify) page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No After this certificate I funeral director, page 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attence.

Just after death.

Jeral Director: After the filled in by 5 ☐ Pending investigation 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

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31. Date filed (Month, Day, Year)

32. Begistrar's Signature

AFI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $J_{u}^{Month}v$ 25° 2011° Helen Louise Shives 16:15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 18518 Old Colony Lane Washington County Hagerstown Social Security Number 7. Age (In yrs. last birthday) f Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Min 213-12-7271 Months Hours Director 92 Yrs Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington County Hagerstown 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18518 Old Colony Lane 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked ot permit. Page 1 and 2 should be fi Department of Health and Mental Important. If item 27 is marked any injury or other traumatic ev 2 William K. Kline Nora Hart Kline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Robertson-sister 13511 Wellspring Dr. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park! 7-28-2011 | Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. north Hagerstown, MD 21740 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he m failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Gastric arcinoms disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter ordering Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death signed by the a 2 🗌 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been siç page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniurv work? 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D21457

Registrar

Box 68760

P.O.

Division of Vital

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25418 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sisouphanh  $J_{u}^{\text{Month}}$ Day 2011 Year Srathsavong 21 5:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours June 25, 1952 579-04-6546 **Director** 59 Vietnam Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7806 Briardale Terrace 20855 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc Completed by 1 Never Married 2 Married Specify: Asian 1 Yes 2 No Specify: 3 ₺ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Seafood Restaurant Own Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tran Van Yup Chansouk Keokenekanlaya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7806 Briardale Terrace, Derwood, MD 20855 Lany Srathsavong/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State  $J_{2011}^{124}$ 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA re of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that au ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death reseivatory failure Physician/ disease or condition minutes Medical resulting in death) Examiner liver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hepatitis c alcohol abuse Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No 1 Marient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 

✓ Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical center Drive, Rockville, Maryland 20850 zhang, mD 9901

State

Registrar

31. Date filed (Month, Day, Year)

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Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25419 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:30a<sub>M</sub> Physician/ Somarriba **ጛኄህ 18%, 201**⁴ሞ Antonio Gutierrez Marcos Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Montgomery Silver Spring Holy Cross Hospital Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-55-1091 1 **K** M 2 □ F Days Min 642941940 Nicaragua Yrs. Director Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location
Silver Spring 10d. Inside City Limits Director Md Montgomery 1 ☐ Yes 2 ☐ No I Hygiene. other than "natural", or items 23a or vent, the Medical Examiner must be r 10e. Street and Number 10f. Zip Code 20902 10g. Citizen of What Country? Funeral Nicaragua 2121 Hermitage Avenue 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 ★ Never Married 2 ☐ Married þ 1 X Yes 2 □ No Nicaraguan Maryland 21215-0036 White If Yes, Give Year or Dates 3 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Consulate Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other transmission. Chauffeur Nicaragua Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Juana Somarriba Eulogio Gutierrez ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121 Hermitage Avenue Silver Spring, Md Mafalda Guerrero/Companion Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Silver Spring, Md Gate of Heaven 7/25/2011 4 Donation 5 Other (Special) PHITE TO PAGE SERVICE, F.A. 21. Signature 9241 Columbia Blvd.Silver Spring,Md20910 Mull 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Opert and Death Immediate Cause (Final End stage renal failure Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) wks Examiner Pseudomonas pneumonia Sequentially list conditions, Examine Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying yrs and C.O.P.D. or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last burial physician s the burial Ischemic congestive cardiomyopathy yrs Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ type II diabetes mellitus Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown resistant enterococcus in liver 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsv death? 1 Yes 2 No 1 Yes 2 Ho 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certificate: To 1 Yes 2 No 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 24 hours after death. Funeral Director: After thi eted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4  $\square$  Homicide City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Registrar

State

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29b. Signature and title of certifier Darbara

(Check

RSM MD

rypanich

30. Name and address of person who completed cause of death (Item 23a) Type Print) Forest Glen Road Silver Spring, Md Barbara Supanich MD 1500 Forest Glen Road Silver Spring, Md

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D 0065485

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:05 Å M Physician/ STERN Mary G. Muly 22 ay 2011 ear Medical 4a. Facility Name (if not institution, give street and number) Sunrise Assisted Living Columbia **Examiner** 4b. City, Town, or Location of Death County of Death Howard Columbia Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Hours Min. 0ct. 24, 1920 New York, NY 135-14-6998 **Director** Yrs. 90 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo MD Montgomery Takoma Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Hickory 20912 U.S.A. Ave. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc ģ 1 Never Married 2 Married Yes 2 X No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Ma College (1-4 or 5+) Elementary/Seconday (0-12) Secretary Elementary School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fannie Blacksburg Abraham Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Stern / daughter 14 Hickory Ave., Takoma Park, MD 20912 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Twp. of Washington, July 24,2011 4 Donation 5 Other (Specify) Cemeterv Toretrinsky Hebrew Funeral Home 21. Signature of Funeral Service Licensee <u>254 Carroll St., NW, Washington, DC</u> 20012 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final 2 naytend Peath Physician/ Pulmonary Fibrosis disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): Physician/Medical Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Tes 2 🗌 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 4 Nursing Home 5 Residence 6 X Other (Specify) Assisted 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury Division 1 Yes 2 No Completed filled in by the f Accident Suicide Investigation 6 Could not be 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

M.D.

29c. License number

D 56531

29d. Date signed (Month, Day, Year) July 22, 2011

21045

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 17, per fh. g924 2-28-12 sm State of Maryland 7 Department of Health and Mental Hygiene State
Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup>2011 Physician/  $\mathbf{July}^{\mathsf{Month}}$ Maria Francisca Torres-Avala 21 10:50 aM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1417 Billman Lane Montgomery Silver Spring 5. Social Security Number 8. Date of Birth (Month, Day, March 12 **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days 1 □ M 2 🕅 E Hours Min. El Salvador 607-01-1925 Director 73 1938 Usual Residence of Decedent or 28a-f shov 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Medical Examiner must be notified at Director 10d. Inside City Limits MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1417 Billman Lane 20902 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 5 þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☑ Yes 2 ☐ No Specify: Salvadorean "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home other traumatic event, Be permit. Page 1 and 2 should be filed. Department of Health and Mental Information of the any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jose L. Torres Maria Jesus Ayala Luis Torres 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ofelia E. Hernandez/Daughter 1417 Billman Lane, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State July 26 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2011 Silver Spring, MD eneral Service License Francis J. Collins Funeral Home Inc. 00 University BLvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) End-Stage Heart Disease Medical Due to (or as a consequence of) Examiner Peripheral Vascular Disease Sequentially list conditions Examiner e attending physician and ed for use as the burial-transit cause. Enter Underlying Cause (Disease or linjury Due to for as a nonsequency of To the Hospital or Attending Physician: The law requires that the death certificate be executed Diabetes Mellitus that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Chronic Renal Insufficiency Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has rail director, page 2 a autopsy performed? Yes 2 X No death? 2 No : After this certifications of the thick of Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2X No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No neral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3.

State Registrar DHMH 17 Rev 7/2009 only one)

31. Date filed (Month,

29b. Signature and title of certifier

Jocetyne

Jocelyne Kouatchou, MD

Month, Day, Year)
JUL 2 5 2011

Kerla

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D63748

4041 Powder Mill Road, #600, Calverton, MD 20705

29d. Date signed (Month, Day, Year)

July 22, 2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	arylan	•				1ental Hy	giene				
			State Registrar			Cer	tificate c	f Deat	h		Reg. No	ΩШ		25422	
	Physicia	n/	1. Decedent's Name (First, Middle,	<i>'</i>						2. Date of De Month July	Day	2011 Year	r	3. Time of Death	
	Medic	al	Israel Nkogwa  4a. Facility Name (if not institution, g				4b. City, Tow	ar Looot	ion of Dooth	July	21,			10:25 a <sup>M</sup>	
	Examin	er	Holy Cross Hos				Silve					ounty of De <b>lont</b> go		rv	
	Funeral		5. Social Security Number 6	. Sex 7. Ag	je (In yrs. la	ast birthday)	If Under 1 Ye	ar If Ur	nder 24 Hrs.	8. Date of Bir	th	9. E	Birthpla	ce (State or Foreign	
	Director		None	1 🖾 M 2 □ F	C	Yrs.	Months Da	ys Hou	irs Min.	July 2	20, 20	11	Country	MD	
	how how	=	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Loc	ation						100	d, Inside City Limits	
	laryla 3a-f s iffied	Director	MD P.G.		6	reenbe	1+							1 ☐ Yes 2 🔀 No	
	the Mor 28	اقًا	10e. Street and Number		<u> </u>	reembe	10f. Zip Coo	le			10g. Citize	n of What (	Country	y?	
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	death item ier m		11. Marital Status	12. Was Decedent Armed Forces?			Vas Decedent	of Hispanic	Origin? (Spe	cify Yes or No- Rican, etc.)	14	. Race - An Black, Wh			
99	after il", or xamii	d by	1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give			☐ Yes 2 ☐			, ,	Sp	ecify: B1	ack	•	
9	nours natura ical E	Completed	15, Decedent	Year or Dates.		16a. Deced	ent's Usual Oc	cupation			16b. Kind of Business Industry			_	
215	n 72   e. ian "r Med	dmo	(Specify only highest Elementary/Seconday (0-12)	grade completed) College (1-4 or s	5+)	(Give k	ind of work do NOT use reti	ne during i	most of worki	ng	Tob. rund	Of Eddition	30 11100	ony	
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and	e filec ntal H ed otl even	To B	17. Father's Name (First, Middle, Last Lekealem Hilary							Name (First, Middle, Maiden Surname) eza Clementine Nkemasong					
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<u>E</u>	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.				eaven C		ry Ji	1141 <sup>26</sup>	Silve	er Sp	rin	g, MD	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Furieral Service Lic	mee Myhra	7						1 Home	Inc	ino	, MD 20901	
		Н	. opr.	1	Approximate										
المنتدعة	Physician/		shock, or heart failure. List onl Immediate Cause (Final disease or condition				2							nterval Between Onset and Death	
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	g <b>A</b>	Examiner	if any, leading to immediate cause Enter U denying Cause (Disease or iinjury	Due to (or as Metaboli									2 harres		
	xecute	Еха	that initiated events resulting in death) Last	ence of):							+	3 hours			
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Division of Vital Records, P.O. Box 68	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of d	eath 5 ∟	Other (specify	)				WOITH		ay rou	
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2	tal or			building, et	с. (Ѕресіту)	)				City or To	vn, State)				
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	fedical	(Check 2 Medical Exa	hysician: To the best of iminer: On the basis of e urse Practioner: To the	xamination	and/or investi	gation, in my o	oinion, dea	th occurred at	the time, date	and place, ar	nd due to th	ne caus		
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			30. Name and address of person who Dawn Walton, MD					1	o :	.m. c	0010				
			31. Date filed (Month, Day, Year)	1500 For				rver	spring	, MD 2	0310				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 450PM 06 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Jashin Social Security Number 7. Age (In yrs last birthday) If Under 24 Hrs 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 D Hours (Month Pay, Director er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 🗓 0e. Street and Number 10g. Citizen of What Country? Funeral Was Deceue... Armed Forces?. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Completed 3 Widowed 4 Divorced 011 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. M Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 4 Donation 5 DOther (Specify 21. Signature of Fundam Service Line 22. Name and Address of Fa of 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fi ediate Cause (Final Ph\_sician/ Drova Jua Medical resulting in death) Due to (or as a consequence of) **Examiner** Secure fielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, tibrillation 4 Unknown Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has lipage 2 s autopsy performed? Yes 2 No this certificate 10 1 Yes 2 No Division of Vital director, 25. Was case referre to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) moren 140 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 Day 3 2 OLL 5:00 PM ORTHA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Deat CENTER WNEARUNDEL MEDICAL MNAPOLIS ANNE + KUNDE Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Hours (Month Bay, Year) 1931 Ohio Director 579-42-1787 80 Usual Residence of Decedent 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Prince George's Upper Marlboro 10e, Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 14108 School Lane 20772 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗡 No Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) P.G. County Elementary/Seconday (0-12) College (1-4 or 5+) 12 Chief Liaison to Clerk of Court Circuit Court 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Herbert Dortha Mae Bailev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20736 William S. Welch III, 9915 Lucky Lure Lane, Owings, MD son other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If it any injury or o once, 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Zion Church Cem. 07-28-11 Lothian, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home. P.A. Wille 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UNG Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) -transit death certificate be executed and Due to (or as a consequence of) resulting in death) Last as the burialattending physician Physician/Medical Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Dav 9 Unknown Unknown or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has ral director, page 2 s autopsy death? performed? Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital 2 X No 1 🗌 Yes Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Funeral Director, After sompleted filled in by the funer 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral L Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of certifier 07-23-2011 PHYSICIAN 20051024 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dew PIKWY ANNAPOLIS, MD 21401 2001 MEDICAL + M.D. WIKOMEUS 31. Date filed (Month, Day, Registra s Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Doris Lorraine Washington 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Washington Hagerstown 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth **Funeral** Age (In yrs. last birthday) Hours (Month, Day, Year) Aug. 21, 1935 1 - M 2 X F Min. Maryland **Director** 214-34-9882 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location death with the Maryland must be notified at Director 1 X Yes 2 □ No Washington Maryland <u>Hagerstown</u> 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7 East Washington Street 21740 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc ō þ permit. Page 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 icensed Practical Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John D. Douglas Gladys May Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christa Williams (Daughter) 22150 McQuay Lane Middleburg, Virginia 20117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Hagerstown Crematory |July 29,201|| Hagerstown, Maryland 4 Donation 5 Other (Spegi 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ signed by the atte Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 ANO Yes 2 W completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 XVo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No Natural 5 Pending Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - OPAL CT. Hageistown JW-3 13HA

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Marylands State of Marylands State	•	ertificate of E		Mental Hy	giene Reg. No 201	25426	
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath Day Year	3. Time of Death	
	Medic	cal	Sheila She-Wu Shu Yu					24, Day 2011 Year	7:00 a <sup>M</sup>	
	Examin	er	4a. Facility Name (if not institution, give street and number)  Bethesda Health & Rehab.		4b. City, Town, or Bethesd	r Location of Death ${ m d} {f a}$	n	4c. County of De		
	Funeral		5. Social Security Number 6. Sex 7. Age (In ye	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		th 9. B	Birthplace (State or Foreign	
	Director		214-84-3351	88 Yrs.	WOTHING Days	Hours Ivin.	March 2	7, 1923	China	
	land f show ed at	to		. City, Town or Lo	ocation				10d. Inside City Limits	
	3 Mary r 28a-1 notifie	Director	VA Fairfax	Fairfa					1 Yes 2 No	
	/ith the 23a or st be	ral	10e. Street and Number 4111 Hunt Road		10f. Zip Code			10g. Citizen of What C	Country?	
	items	Funeral	11. Marital Status 12. Was Decedent Ever in	U.S. 13.	2203 Was Decedent of His	ispanic Origin? (Sp	pecify Yes or No-	USA 14. Race - Am		
920	ould be filed within 72 hours after death with the Maryland told Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married  3※②Widowed 4 ☐ Divorced  Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	- 1	If Yes, specify Cubar  1 ☐ Yes 2 🛂 No		o Rican, etc.)	Black, Wh		
15-0	2 hour "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d		rkina	16b. Kind of Business Industry		
121	within 7. /giene. ner than t, the Me	Com	Elementary/Seconday (0-12) College (1-4 or 5+)	life. D	nemaker	Own Home				
2 pu	be filed w lental Hygi rked other ic event, i	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle,	Maiden Sumame)		
ylar	should be file and Mental P is marked o raumatic eve	은	Ka Ming Shu			Shao Ch	ing Wu			
, Maryland 21215-0036	d 2 shoulalth and n 27 is n er traum		19a. Informant's Name/Relationship (Type, Print)  Chun Wai Yu/Daughter		ing Address <i>(Street a</i> . Hunt Roa			r, City or Town, State, 2 22032	Ip Code)	
Baltimore,	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	b. Place of Dispo cemetery, cren		101	Date 11 × 130	20c. Location - City of		
Baitir	permit. Postarime mportar any injur		21. Signature of Fulleral Service Librasee	22	2 Name and Address	o of English		Silver Sp:		
		ilver Springest,	Approximate							
~	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	deme	ntia				Interval Between Onset and Death Unkneww	
	Medical Examiner		resulting in death)  Due to (or as a conse							
	+-0	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	equence of):						
	and	Examiner	Cause Unisease or impury that initiated events resulting in death) Last  Due to (or as a conse	annon of						
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χ οχ Χ	th certi ttendir or use	lan/	23b. Was decedent pregnant 23c. If yes, outcome of preg	etal death 3	☐ Ectopic pregnancy	у		23d. Date of d	,	
J. BOX	the deal by the a' ached fe	Physician/M	1   Yes 2   Yes 4   Pregnant at time of g   Unknown	of death 5	Other (specify)			Month	Day Year	
S, P.O.	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial transit	þ	Part II. Other significant conditions contributing to death but not read to the part of th			en in Part I.		obacco use contribute t	to the cause of death?  Probably 4 Unknown	
Vital Records,	w requisible beer 2 should	Completed	Adult failure to	Hav	he.		24a. Was a	an 24b. Were a	utopsy findings available	
ב	The la ate ha page ?	Com	Hypertens; on				autop perfor	rmed? death?	o completion of cause of	
0	ician; certific rector,	Be	25. Was case referred to m dical		26. Plac	ace of Death (Chec	ck only one)			
>	y Phys ar this c eral dir	e:	1 ☐ Inpatient 2 ☐ 27. Manng of Death 28a. Date of injury	28b. Time of	nt 3 🗆 DOA	4 Nursing Ho		ence 6 Other (Spe	cify)	
DIVISION OF	tending death. tor: Afte the fun	Certificate:	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be	) injury	work? M 1 □ Y	Yes 2 No	Zou. Describe in	JW ligury Occurred	-7-81381	
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   23d. Date of deliver   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   5   Pending   Month   5   Pending   Month   5   Pending   Month, Day, Year)   1   Personal at time of death   5   Other (specify)   Month   5   Pending   Month, Day, Year)   1   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   5   Other (specify)   Month   1   Personal at time of death   1   Personal at										
	he Hosp in 24 hou he Funei ipleted fil	Medical	29a. Certifier 1 Certifying Physician: To the best of my knot (Check 2 Medical Examiner: On the basis of examinat only one) 3 Certifying Nurse Practioner: To the best of	ition and/or investi	tigation, in my opinion	<ul> <li>n. death occurred a:</li> </ul>	at the time date ar	nd place, and due to the	cause(s) and manner stated	
	To the		29b. Signature and title of certifier  Chrowdur		29c. License			29d. Date signed (Moni		
	5	-		em 23a) (Type, P			-	1/07/	/	
			30. Name and address of person who complete dicause of death (Ite  NURUL CIFUIND JURY, M 31. Date filed (Month, Day, Year)  JUL 2 6 2011	10/1-	5216 DI	NO DR	?IVE, 6	BURTONSU	11616 W/J	
	State Registra	_	JIII 2 6 2011	lature bau	ر الم					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Virginia Cabell Appleby August 2011 2:45pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 517 Piney Run Court Sykesville Carroll Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under **Funeral** If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth Months Days Hours Sept. 13, Director 217-12-6919 90 Yrs 1920 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Carroll 1 ☐ Yes 2 🛣 No Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 517 Piney Run Court 21784 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 3 X Widowed 4 Divorced If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐XNo Specify: "natural" White Completed Specify other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Copy Editor/Ad Designer Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) Frederick Mortimer Cabell Bessie Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia T. Finecey (Daughter) 517 Piney Run Ct., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 1 Cremation 3 Removal from State any injury or 22011 4 Donation 5 Other (Specify) All County Cremation Sykesville, MD Signature of Funeral Service License 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA M00764 PO Box 195 Sykesville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COP Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause Disease or imjury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for 1 in the past 12 months? Month Day Pregnant at time of death the detached 9 Unknown ģ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should been Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy After this certificate performed' death? 1 🗌 Yes 1 Yes 2 No 2 1 N 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ■ Residence 6 □ Other (Specify) within 24 hours after death.

To the Funeral Director; After thi
completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide Investigation 1 Tes 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and use to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 only one) 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

AUG 1

D0037606

6190 Georgature Blus, Elderburg

25428

			for State Registrar	Otato or mar		tificate of L	Death	,	Reg. No			
	Physicia	in/	Decedent's Name (First, Middle, La.	st)				2. Date of De Month	Da	y Year	3. Time of Death 2:10 p M	
ar da	Medic Examin	cal	Anthony  4a. Facility Name (if not institution, give		rmetta	4b. City. Town, o	r Location of Death	Augus		2011 County of Death	<u> </u>	
- erfte <sub>e</sub> t	Ladilli		Country Care Far		Living	Westmi				Carrol		
	Funeral Director		210 12 0739	ex 7. Age (li	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Nov 9	1921		nplace (State or Foreign intry) MD	
	ind thow at		Usual Residence of Decedent  10a. State 10b. County	11	0c. City, Town or Lo	cation					10d. Inside City Limits	
	Aaryla 8a-f s tified	rect	MD Carrol	1	Sykesvil	le					1 ☐ Yes 2 ☐XNo	
	with the Assa or 2 s 23a or 2 nust be no	Funeral Director	10e. Street and Number 107 Taft Terrace		-	10f. Zip Code 21784			10g. Cit	izen of What Col	untry?	
9600	ge 1 and 2 should be filed within 72 hours after death with the Maryland rt of Health and Mental Hygiene.  E. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates.		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🟋 No	an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		14. Race - Amer Black, White Specify: who	, etc.	
21215-0036	vithin 72 ho iene. ir than "nat the Medica	Completed by	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)		(Give life. D	dent's Usual Occup kind of work done ( O NOT use retired) penter	during most of wor	king	16b. K	ind of Business I A	ndustry	
pu	filed val Hyg	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, Maiden Surname)				
yla	Ment Ment narke	은	Joseph Armetta				Stefa	nina Mu	ffol	etto	<u>.</u>	
Maryland	2 shou th and 27 is m traum		19a. Informant's Name/Relationship (7 Mrs. Bernice Arme		.			ral Route Number, City or Town, State, Zip ${ t esville,   t MD  21784}$			Code)	
Baltimore,	Page 1 and nent of Heal ant: If item ; ıry or other		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, crer	osition (Name of matory or other place	ce)	Date	20c. Lo	ocation - City or		
ltin			4 Donation 5 Other (Special Signature) of Funeral Service License		All Coun				Syk	esville.	& CHAPEL,PA	
B	permit. Departr Imports any inji	J	Duar L.+	wat M	00 169 ]	PO Box 19	5 Sykesv	ille, M	D 217	784	& CHAPEL, FA	
	Pny icion Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	rest,		Approximate Interval Between Ouset and Death						
0	icate be executed physician and sthe burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):									lyen	
. Box 68760	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the first section of the fi	Fetal death 3	Ectopic pregnand Other (specify)	cy			23d. Date of deli Month	ivery Day <b>Y</b> ear	
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of Vital Records,	sician: The law require certificate has been s irector, page 2 should	Completed						24a. Was auto perfo 1 \(\sum \text{Yes}\)		prior to c	opsy findings available ompletion of cause of	
/ital	ysician is certifi director	o Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:	2 T FR/Output	LOth	ace of Death (Chec	No.		No.	Asseedhe	
	ding Phy th. After this funeral d	cate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Yo	2 ER/Outpatier 28b. Time of injury	28c. Injur work	y at	28d. Describe t		Other (Speci y occurred	County Ceny	
Division	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	I Certificate:	3 Suicide 6 Could not be 4 Homicide determined					28f. Location (\$ City or Tov			al Route Number,	
	the Hospit nin 24 hour the Funera	Medical	only one) 3 L Certifying Nur	sician: To the best of my iner: On the basis of exan se Practioner: To the bes	knowledge, de the nitration and a lives at of my knowledge, o	occured at the time tigation, in my opinion death occurred at th	e, date and place, a on, death occurred a e time, date and pla	and due to the ca at the time, date a ace, and due to th	iuse(s) an and place ne cause(s	nd manner as sta , and due to the c s) and manner as	ted. ause(s) and manner stated. stated.	
	To t To t		29b. Signature and title of confifier	Ble	1	29c. License	rumber 7949		29d. Dat	eyust	, Day, Year) 8-8h 2012	
			30. Name and address of person wh	completed cause of deat	(Item 23a) (Type, F	Print)				·	21107	
4.	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature Signature	Leverest	here S	ebel	201	weed	mitte Mir	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25429 State
Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 2011 August 11:08 PM Darryl Keith Brantley Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring 10415 Gatewood Terrace 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 96<u>4</u> 1 🛛 M 2 🗆 F Months Days Hours Min Washington DC **Director** 215-94-5293 Usual Residence of Decedent show 10a. State 10b. County with the Maryland at 10c. City. Town or Location 10d. Inside City Limits Director r 28a-f st notified a 1 X Yes 2 No Silver Spring Maryland Montgomery 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be r Funeral 20903 United States 10415 Gatewood Terrace items ; within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. Completed 3 Widowed 4 Divorced Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Media Public Relations traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Phyllis Loretta Edmondson Julius Knight Brantley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 st trnent of Health a tant: If item 27 is 10415 Gatewood Terr. Silver Spring, MD 20903 Julius Knight Brantley/Father other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 8/10/2011 Woodbine, Maryland Flinal . Signadure of Funeral Service Licen Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Non Hodgkin's Lymphoma of the Stomach disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HIV Infection Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last nding physician and Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 s the r use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate Yes 2 K No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 🗶 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛭 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatl 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆

within 2 0

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1355 Piccard Dr. Rockville,

32. Registrar's Signatur

only one)

29b. Signature and title of pertifier

Coleman 31. Date filed (Month, Day, Year) 29c. License number

MD 20850

D37142

29d. Date signed (Month, Day, Year, August 5, 2011

11-05695

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gerald Bonner		St 1- For State Registrar	ate of Mary	and /	Departme <i>Certifica</i>			l Menta	al Hyg		eg. No.	201	1	25430
Physicia Medical Examir		Decedent's Name (First, Middle Gerald Sharo	ld Bonn							Date of Deat Month Iuly 30, 20	Day 011	Year		Time of Death 0243 hrs
		4a. Facility Name (if not institution  Johns Hopkins Bayvie	ew Medical Ce	nter			D. City, Town, or L Baltimore					County of De		
Funeral Director		5. Social Security Number 217-04-2122	6. Sex	7. Age (	In yrs. last birti	hday) Yrs.	If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 8  Months Days Hours Min. 06  07/24/1980					9.80 9.80	Birthr reign Coun	olace (State or try) MD
und show any uce.		Usual Residence of Decedent  10a. State  10b. County	/ 7	10	c. City, Town									0d. Inside City Limits
th the Maryland 23a or 28a-f sho notified at once	irector	10e. Street and Number	/A				imore 10f. Zip Code			10	_	en of What C	ountr	**
eath with th items 23a ust be notif	Funeral Director	5505 Bowleys  11. Marital Status  1 Never Married 2 Ma	12. Was De	cedent Ev	er in U.S.		212( Decedent of Hisp s, specify Cuban,	anic Origin					nerica	n Indian, Black,
æ 2 W	੬	3 Widowed 4 Dive	orced If Yes, Give Ye	ar	eted) 16a. [	Decedent's	es 2 X No Usual Occupation	n (Give kin			Specify: Bla			
7	Completed	Elementary/Secondary (0-12)  12th Grade		1-4 or 5+)			oyed		Ź			N/A den Surname)		
Id be fents	æ	17. Father's Name (First, Middle, Clyde Hooks  19a. Informant's Name/Relationsl	Bonner		l 19b	. Mailing /	Address (Street	Yvor	nne	Washi	ngt	con	ate 7	in Code)
imore, MD 2 Pages 1 and 2 shoul ment of Health and N tant: If item 27 is re	-	Cheryl Bonne 20a. Method of Disposition	r(siste		20b. Place of	902 f Dispositi	N. Nori	folk	Ave		alti		, 1	ND 21215
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumatiinjury or other		1 Burial 2 Acremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: on-site Crematory 08/12/11 Baltimore 21. Signature of Funeral Service Licensee 22 Normal Service Crematory 08/12/11 Baltimore												
Balt Balt Depart Import	Physician  23a. Part I. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												re	, MD21217 Approximate Interval
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds  Due to (or as a consequence of):										-	Between Onset and Death	
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b Due to (or as	a consequ	ence of):								1	
asit ed	Ex	events resulting in death) Last  Due to (or as a consequence of):												
ox 68760, sath certificate be execute attending physician and attending physician and for use as the burial - trans		UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes,	outcome of	INF,G9 of pregnancy	_	_	_				Date of deliv	-	Van
Box 6876 e death certificate the attending phy ed for use as the t	Physician	past 12 months?  1 Yes 2 No 9 Unk		nant at tim	e of death 5		death 3 r ( <i>Specify</i> )	Ectopic pr	regriancy		a . "	Month	Day	Year
ires that the signed by a	2	Part II. Other significant conditi	ons contributing t	o death bu	it not resulting	in the und	ferlying cause giv	en in Part I						cause of death?
Records, The law require ficate has been si page 2 should b	Completed		<u> </u>				<del>-</del> -		- [	24a. Was a autops perform	sy m <u>ed</u> ?	prior death	to com	sy findings available inpletion of cause of
tal Rec	9 9	25. Was case referred to medical examiner?					26.Place o		neck only	one)				
n of Vi	의	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi	28a. Date		2 <b>E</b> R/Out 28b. Ti 0240	ime of Inju	ry 28c. Injury		28d	ome 5 [ ] F Describe h Dject shot	ow injur		her:	
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	Certification:	2 Accident Invest 3 Suicide 6 Could	tigation 28e. Plac	e of Injury		m, street,	factory, office bui		28f.	or Town, St	ate)	d Number or		Route Number, City
To the Hospi within 24 hour To the Funer completely file	ਰ	29a. Certifier 1 Certifying Ph	ysician: To the bearing	st of my kn	owledge, deat				, and due	to the cause	e(s) and	manner as s	tated.	
F 3 F 8	Me	29b. Signature and title of certifier									ate signed <i>(i</i>	Month	Day, Year)	
4			who completed cau uty Chief Medi		,	) W. Ba	Itimore Stree	t, Baltim	ore, MI	21223				
Sta Registr	_	31. Date filed (Month, Day, Year) AUG 1 0 20	)11 R	egistrar's S	signature	arke	1							
DHMH 17 Rev 1/200	1		100	-	ORI	GINAL	•				(	DOME		, , , , , , , , , , , , , , , , , , , ,

1-05615 aymond Belton	1	Please Type or Print in Black Indelible Ink. Ensure				
. 6		State of Maryland / Department of Health and  1-For State Registrar  1. Decedent's Name (First, Middle, Last)	Mental F	R	201 eg. No.	
Physicia Iedical Examir				2. Date of Dea Month July 27, 2	Day Year	3. Time of Death 1620 hrs
		4a. Facility Name (if not institution, give street and number)  5211 Frankford Avenue Apartment C  4b. City, Town, or Lo	ocation of Dear	th	4c. County of Deat	N/A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)   ff Under 1 Year   251-15-3855   1   M 2   F   54   Yrs.   Months   Days	If Under 24Hi Hours Mi	_	1956 Forei	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 33a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	Usual Residence of Decedent  10a. State	anic Origin? ( § Mexican, Puert	Specify Yes or No	White, etc.	10d. Inside City Limits 1 X Yes 2 No ntry? ican Indian, Black,
5-0036 iled within 72 hours a Hygiene. I other than "natura the Medical Exami	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th  N/A  Custodian	O NOT use re	tired)		Industry
115-0	Be Co	II m le		e (First, Middle, Me M. Be	Maiden Surname)	
MD 2121 d 2 should be fi lth and Mental I n 27 is marked numatic event,	일	19a. Informant's Name/Relationship (Type, Print)  Bennie belton-Brother    19b. Mailing Address (Street a   6210   Herriot	and Number or	Rural Route Num	nber, City or Town, State	
Baltimore, Permit. Pages I and Department of Healt Important: If item injury or other tran		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemer crematory or other place)  Greenmount Cemt.	etery, 8/	Date 10/2011	20c. Location - City or Baltimore	• -
Baltir permit. F Departme Importationiumy or		21. Signature of Paneral Service Licensee  Ave. Balti	f Facility M	arch F/ MD 212	H 1101 E	. North
Physician /Medical Examiner	Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Bequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			_	Approximate Interval Between Onset and Death
execul an and al - tra	<u>s</u>	d.  ☑ UNPENDED ☐ AMENDED 23a,pt.II,27,per me,g918	8 8–17-	-11 sm		
on of Vital Records, P.O. Box 68760, sading Physician: The law requires that the death certificate be suit.  r. After this certificate has been signed by the attending physicial te funeral director, page 2 should be detached for use as the burial of the control of the purity of the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Pregnant at time of death 5 Other (Specify) 9 Unknown	Ectopic pregn	ancy	23d. Date of deliver Month I	V Day Year
ires that the signed by	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give  Morbid Obesity; Diabetes Mellitus	en in Part I.		bacco use contribute to	
of Vital Records,  of Physician: The law requir  then this certificate has been so  meral director, page 2 should the	Completed			24a. Was a autop: perfor	sy prior to o med? death?	topsy findings available completion of cause of es 2 No
Vital ysician: his certif	8		Death (Check	, ,	Residence 6 🗹 Other	: Scene
ion of Attending Physicath.  tor: After the funeral	ition: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury a 1 X Natural 5 Pending 1 Yes			now injury occurred	
Division  To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined Could not be (Specify)	ding, etc.	28f. Location (S or Town, St	Street and Number or Ru tate)	ral Route Number, City
	Medical (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date one)  2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, de	and place, and eath occurred	d due to the cause at the time, date a	e(s) and manner as state and place, and due to th	ed. e cause(s)
To the within To the comple	Me	29b. Signature and title of certifier  29c. License n  O.C.M.	number		29d. Date signed (Mo. July 29, 2011	
	-	30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimo	re Street	Baltimore MF	21223	
Sta Registr	-	31. Date filed (Month, Day, Year)  32. Restrar's Signature				

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

11-05810 Linda Billingsley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

CEUNCAIG OF DECAM										25432		
Physicia Medical Exami	ın/	Registrar  1. Decedent's Name (First, Midd		a Louise 1	Billingsl	ey			2. Date of Dea Month August 3,	nth Day Year		. Time of Death 0430 hrs
		4a. Facility Name (if not instituted 1101 Edwight Court	on, give street and nu	mber)		4b. City, Town, Brooklyn	or Location	of Death		4c. County o		
Funeral Director		5. Social Security Number 216–50–3194	6. Sex	7. Age (In yrs. I		If Under 1 Year   If Under 24Hrs.   Months   Days   Hours   Min.			8. Date of Bi Jan 25	rth(MM/DD/YYYY) , 1948	Foreign	olace (State or try) W. Va.
nd how any ce.		Usual Residence of Decedent  10a. State 10b. County  Maryland	N/A	10c. City	, Town or Locat		ltimore	<u> </u>				0d. Inside City Limits
ith the Maryland 23a or 28a-f show	Director	10e. Street and Number 1101 Edwight	Court			10f. Zip Code	21225			10g. Citizen of Wh USA	at Countr	y?
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f shent, the Medical Examiner must be notified at once	by Funeral		arried Armed Fo	2 X No	If Y	s Decedent of es, specify Cut	oan, Mexica No s <i>pecif</i> y	n, Puerto f	Rican, etc.)	White Specify:	etc.	n Indian, Black, White
5-0036 led within 72 hours Hygiene. I other than "natur the Medical Exami	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12	College (1		during m	nt's Usual Occu ost of working I memaker	ife, DO NO	T use retire	ed)		iness/Ind	
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medical	Be	17. Father's Name (First, Middle Lend  19a. Informant's Name/Relations	y H. Billin	gsley	19h Mailine	Address (St	Hel	len L.	Mitchel	Maiden Surname)  1 mber, City or Towr	State 7	(in Code)
	P	Harry R. Billings		Brother)		th Schoo	1house			11e, Penns	ylvani	ia 17364
Baltimore, permit. Pages 1 an Department of He Important: If ite injury or other tr		1 Burial 2 X Cremation 4 Donation 5 Other S 21. Signature of Funeral Service	pecify:	Ba	crematory or oth yview Cre	matory,		8/8/2		Baltimore yniak Fune	•	
Physician	1	23a. Part I. Enter the disease, or			23	87 E. Pat	apsco A	Ave.,	Baltimor	e, Marylan	1 212	225–1856 Approximate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a.Cocaine	Intoxi consequence								Between Onset and Death
	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause		consequence o	A):							
uted od ransit	dical Examiner	(Disease or injury that initiated events resulting in death) Last	C.	consequence c	of):						1	
		<b>X</b> UNPENDED			28a-f,pe	r me,g	91 8-1	17–11	sm			
Box 68760, e death certificate b the attending physical for use as the burner as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Un	ne 1 Live b	ant at time of de	2 Fe	tal death her (Specify)	3 Ectop	ic pregnar	псу	23d. Date of Month	delivery Da	y Year
P.O.		Part II. Other significant condit	ions contributing to	death but not r	resulting in the u	inderlying caus	e given in F	Part I.		obacco use contri	_	e cause of death?  bly 4  Unknown
Division of Vital Records, P.O. Box 6876( tal or Attending Physician: The law requires that the death certificate rs after death.  al Director: After this certificate has been signed by the attending physicial by the funeral director, page 2 should be detached for use as the b	Completed by	25. Was case referred to medica				26 DI	ace of Death	(Chack o	1 🗸 Yes	psy p orm <u>ed</u> ? d		psy findings available mpletion of cause of
Vital hysician this cert	Ö	examiner?	Ulassitati (***)	npatient 2	ER/Outpatient		Other <sub>4</sub>		Home 5	Residence 6	Other: S	Scene
ੂ ਭੂ . ≺ ∄	ation: T	27. Manner of Death  1 Natural 5 Pend		of Injury , Day,Year) -3-11	28b. Time of I	· ·	njury at Wor Yes 2. ∑	_, I,	28d. Describe <b>Unknow</b> i	how injury occurre	ed	
12 o b	Certification:	3 Suicide 6 X Cou 4 Homicide	id not be rmined (Specify)		iome, farm, stree ind at l	-	e building, e			State) 1101		Route Number, City
To the Hos within 24 h To the Fun completely	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the bes	of examination a	lge, death occui and/or investiga	red at the time tion, in my opin	date and p ion, death c	lace, and o	due to the cau t the time, date	se(s) and manner and place, and d	as stated ue to the	l. cause(s)
To with To Con	₩.	29b. Signature and title of certific	and manner s	tated.	-		ense numbe	r		29d. Date signe August 3, 2		h, Day, Year)
Ø		30. Name and address of person Donna M. Vincenti, M	•		n 23a) miner 900	W. Baltimo	re Street	, Baltim	ore, MD 2	1223		
St Regist	ate rar	31, Date filed (Month, Day, Year) AUG. 1 0 2011	32. Re	gistrar's Signat	ure							

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Monti 18:07 PM 201 Î Beegle Donna Marie Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Baltimore Kosedale If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) 8. Date of Birth Months 1 🗆 M 2 🕱 F Hours (Month, Day, Year) Director 213-54-2209 Pennsvlvania Usual Residence of Decedent 28a-f show 10a. State at 10h County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Tes 2 X No MD Baltimore Essex 10e. Street and Number "natural", or items 23a or 10f. Zip Code 10g, Citizen of What Country? Funeral 7 Wilbur Road 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Cruver Clair Leon Turko Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilbur Road, Essex, MD 21221 <u>Janine Beegle / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 K Donation 5 ☐ Other (Specify) 08/09/2011 Anatomy Gifts Registry Hanover, Maryland Signature Funeral Service 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a ronsequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Little Unidentifying Cause (Disease or iinjury Due to (or as a consequence of): and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician by Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death signed by the ar 9 Unknown the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 certificate ☐ Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending hours after death. Accident 1 🗌 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours

To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dr G. DAS (PGY-1) 08/05/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21237

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charlotte Hobbs Barnes 2011 2:16am August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carro11 8. Date of Birth (Month, Day, Feb 2 Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Min. Hours 1 M 2 1921 Director Feb MD 212-12-6635 Usual Residence of Decedent 28a-f shov 'rem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carrol1 Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6150 Deanna Drive 21784 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ XNo If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) domestic should be filed with and Mental Hygien. homemaker Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ William H. Hobbs Sarah Margaret Jones permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Woodward (daughter) 6150 Deanna Dr., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State All County Cremation |8-10-11 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature/of Funeral Service Licensee M60764 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): physician and the burial-transi ause ibisease or imiury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 1 ☐ Yes ≥ L 9 ☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed should 24a. Was an autopsy performed? Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, hours after death. within 24 hours after death

To the Funeral Director: /

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No examiner? 2 No Hospital: Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Watural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

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Certificat

Medical

29b. Signa

31. Date filed (Month

and title of certifier

of person who completed cause of death (Item 23a) (Type, Print) WESTMINSTER, UD Z115 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Marylan State of Marylan	-	artment of F tificate of E			giene Reg. No.20		25435	
	Physicia		Decedent's Name (First, Middle, Last)     ALMA	BOWEN			2. Date of Dea Month AUGUS		Year	3. Time of Death 1:25 P. M	
art.	Medio Examir		4a. Facility Name (if not institution, give street and number)	- OWER		Location of Death	4c. County of Death				
	_		8126 CONDUIT ROAD 5. Social Security Number 6. Sex 7. Age (In yrs. Ia	et hirthday)	PA If Under 1 Year	RKVILLE  If Under 24 Hrs.	8. Date of Birt	BALTIN		RE place (State or Foreign	
	Funeral Director		215-18-5764 1 □ M 2X F 89	Yrs.	Months Days	Hours Min.	(Month, Day 7/29/10	y, Year) 922	Coun	try)	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	្ក	Usual Residence of Decedent           10a. State         10b. County         10c. City	y, Town or Loc	cation				1	0d. Inside City Limits	
		rect	MD BALTIMORE	PARK	VILLE					1 ☐ Yes 2X No	
	th the	Funeral Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	eath wi	-une	8126 CONDUTT ROAD  11. Marital Status 12. Was Decedent Ever in U.S		21234 Vas Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	USA 14. Rad	e - Americ	an Indian,	
9036	rs after de ural", or it   Examine	ь	1 ☐ Never Married 2 ☐ Married  3 X Widowed 4 ☐ Divorced  Armed Forces?  1 ☐ Yes 2 X No If Yes, Give Year or Dates.		Yes, specify Cuba		Rican, etc.)	Blac Specify	ck, White, WH	etc. ITE	
Maryland 21215-0036	iin 72 houi te. <b>han "natu</b> e Medical	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)	(Give k	ent's Usual Occupa ind of work done of NOT use retired)		ing	16b. Kind of Business Industry			
d 21	ed with Hygier other t	Be C	6TH GRADE  17. Father's Name (First, Middle, Last)	НС	OMEMAKER	18. Mother's Nam	e (First, Middle		HOME		
ylan	d be fil Mental arked atic ev	욘	JOHN BRADLEY				E FOLKS		-7		
Mar	2 shouth and the strain trauma		19a. Informant's Name/Relationship (Type, Print)	T-	g Address (Street a					Code)	
re,	1 and of Heal item 2	1 8	ALMA E. PELLETIER/DAUGHTER  20a. Method of Disposition 20b. Pl	lace of Dispos	+ CONDUIT sition (Name of		RKVILLE .	MD 2 20c. Location	1234 - City or To	own, State	
Baltimore,	. Page tment c tant: If jury or		4 □ Donation 5 □ Other (Specify)	ELAND N	NEMORIAL	PK. 8/1	2/2011	HILLENI			
Bai	permit Depart Impor any in	8	21. Signature of Funeral Service Licensee MOO217	22.	Name and Addres	s of Facility <b>TH</b> I RAVEN B	E JOHNS LVD. T	ON FUNE OWSON, I	RAL H	IOME, P.A. 1286	
	Physician Medical	4	23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause reach line.  Immediate Cause (Final disease or condition resulting in death)	i. Do not enter	r the mode of dying	g, such as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death	
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	od Sit	Examiner	Sequentially list conditions, b.  The top or as a consequence. Enter Underlying								
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P.O. Box 687	the Hospital or Attending Physician: The law requires that the death certificate be executed that 4 hours after death.  The Abours after death.  The Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No g ☐ Unknown  IF FEMALE: 23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	Ideath 3 🗌	Ectopic pregnanc Other (specify)	у			te of delive	ery Day Year	
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01 <	I or Attending Physician: after death. Director: After this certific in by the funeral director,	e: To	27. Manner of Death 28a. Date of injury	28b. Time of	28c. Injury	4 □ Nursing Ho at		lence 6  Oth		)	
0	tendin leath. tor: Afti the fun	Certificate:	10 Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	injury		? Yes 2□No					
Division of Vital Records,	tal or At rs after o al Direct ed in by		4 Homicide determined 28e. Place of Injury - At hor bullding, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,	
	To the Hospital or within 24 hours aft To the Funeral Dir completed filled in	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowle (Check 2 Medical Examiner: On the basis of examination	n, death occurred at	the time, date a	nd place, and du	e to the cai	use(s) and manner stated.			
	To the within To the compl	Σ	only one) 3 Certifying Nurse Practioner: To the best of my 29b. Signature and title of certifier	Knowledge, de	29c. License			29d. Date signe	-		
					104	1536		8)0	1))	1	
			30. Name and address of person who completed cause of death (Item  31. Date filed (Month, Day, Year)  32. negistrar's Signatu	60]	boh	Rave	m B)	VA, 1	391	1-MD212	
	Stat Registra		AUG 1 0 2011	1. pa	Mad						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month alomon 2011 /Medical 4a. Facility Name (If not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death Examiner Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-13-1920 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday, **Funeral** Days 1**4** M 2□ F Months Hours Min. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 Exes 2 □ No Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No þ Specify Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working tie. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle 18. Mother's Name (First, Middle, Maiden Sur Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked of any Injury or other traumatic ever ပ Informant's Name/Relationship (Ty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Marbara 70 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 15-2011 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens Dan 23a. Fart 1. Enter the disease, or complications that of ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 5 minues disease or condition resulting in death) ardiac /Medical Due to (or as a consequence of) thero-sclerotic 5410 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner seizuves 1040 Due to (or as a consequence of). tupothyrold 13m Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Tyes 2 DNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an autopsy performed 1 □ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760会 s been signed by the should be detached this certificate I To the Hospital or Attending Physician: eral Director: After th filled in by the funeral within 24 hours a

To the Funeral I

Baltimore, Maryland 21215-0036

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

D30494

Baltimore MD VIXXA

8-8-2011

State

Registrar

DHMH 17 Rev 1/2001

maidenchoice lone

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 12:30 Рм Arince Pierre Cadet August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Randallstown Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth January 24,1934 Birthplace (State or Foreign Country)
 Uniti 7. Age (In yrs. last birthday) Funeral Days Hours 1 X M 2 □ F 054-66-9796 Director Yrs Haiti Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Owings Mills 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 3410 Associated Way, Apt. 209 21117 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed black the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event". (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) musician music Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Luxama Cadet Odeide Ceide 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dominique Cadet/daughter 3805 Ellerslie Ave. Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem GardAug. 6, 2011 Timonium, Maryland 21. Signature of Funeral Service Licensee John O. Mitchell TV, Funeral Services of Dulaney Valley, 200 E. Padonia Rd. Timonium, MD 21093 P.A. 23a. Parri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Aspiration pneumonia Medical Due to (or as a consequence of) Examiner Urinary tract infection Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed hypertension that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Parkinsons disease Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No detached 9 Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 XX No Other: 1 Tyes Certificate: To 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caus 29a. Certifier nation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D2715

Registrar

State

3100 Lord Baltimore Dr., #110

Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Regist ar's Signature

Raynold Depestre,

31. Date filed (Month, Day, Year)

AUG 1 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25439 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Conte 201 Î August 11:00 P.<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec. 21.1934 1 X M 2 □ F Months Hours Min. New Jersev 139-26-3209 76 Director Usual Residence of Decedent show 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Bel Air 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2064 Rainier Avenue 21015 U.S.A. items ( 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. "natural", or 1 Never Married 2 X Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Project Manager Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2011 ဂ James Conte Kate Carbone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Forsatz Conte 2054 Rainier Avenue, Bel Air, Maryland 21015 AUGUST 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 □ Donation 5 🗓 Other (Specify) Entombment Calvary Mausoleum 8-9-11 Paterson, New Jersey 22. Name and Address of Facility Marzullo funeral Chapel, P.A. Signature of Funeral Service Licensee 6009 Harford Road,Baltimore,Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician! disease or condition resulting in death) END STAGE DEMENTIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ JAMES CONTE icate has been sig r, page 2 should b Completed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate | 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tyes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural injury 5 Pendina 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Investigation M 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title ess of person who completed cause of death (Item 23a) (Type, Print) JAĆKIE JONES, 2300 DULANEY VALLEY RD. CRNP TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 0 2011

DHMH 17 Rev 7/2009

State Registrar SINAI HOSPITAL OF BALTINONE, 2401 W. Belvedere Ave, Registrar's Signaline

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EMILL AND, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25441 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month August 2011 Walter Wiley Comer Sr. 4:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Harford Memorial Hospital Havre de Grace 9. Birthplace (State or Foreign Country).
Maryland Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Director 217-36-2520 Aug. Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location ä 10d. Inside City Limits Director th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f si traumatic event, the Medical Examiner must be notified. 1 XYes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 711 Webb Street 21001 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Plumbing & Heating Co. Owner / Operator Be **Baltimore, Maryland** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Harry Comer Sr. Margaret Virginia Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Rochelle M. Comer / Spouse <u>711 Webb Street, Aberdeen, Maryland 21001</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 08-11-11 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gdn. 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service License 1317 Cokesbur Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEPHALOPATH Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner RESPIRATORY TYPOXIC Secure tielly list as writions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 687 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by -SEVERE Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural injury work? 1 🗆 Yes 2 🗀 No 5 Pending M Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of o 30. Name and address of person who completed cause of death (Item 23a) (Type Print) State Registrar

				Department of Health and M Certificate of Death	lental Hygiene Reg. No	2011 25552
	Physicia		Decedent's Name (First, Middle, Last)     SUSAN D. DOWNEY		2. Date of Death Month Day	3. Time of Death
ر دور	Medie Examir		4a. Facility Name (if not institution, give street and number)  Franklin Squase Hospital	4b. City, Town, or Location of Death	4c.	County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		8. Date of Birth (Month) Day Year)	9. Birthplace (State or Foreign MARYY) AND
	Maryland 28a-f show otified at	rector	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town           MD         BALTIMORE         PARK	or Location	<del>.</del>	10d. Inside City Limits 1 □ Yes 2 🛣 No
	s 23a or 2	by Funeral Director	10e. Street and Number 2229 ELLEN AVENUE	10f. Zip Code 21234	10g. Cit	izen of What Country? USA
9200	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1  Never Married 2  Married 3  Widowed 4  Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1  Yes, 2  No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Sper If Yes, specify Cuban, Mexican, Puerto F     □ Yes 2 ☒ No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHTTE
Maryland 21215-0036	within 72 ho giene. er than "na er the Medic	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of workir life, DO NOT use retired) SCHOOL TEACHER	ng	EDUCATION
yland	should be filed within 7 h and Mental Hygiene. 7 is marked other than traumatic event, the M	To Be	17. Father's Name (First, Middle, Last)  DONALD W. DOWNEY		(First, Middle, Malden S	Surname)
	I and 2 shou F Health and Item 27 is m other traum		DONALD DOWNEY/BROTHER 22 20a. Method of Disposition 20b. Place of	Disposition (Name of	TIMORE, MD	Town, State, Zip Code) 21234  coation - City or Town, State
Baltimore,	mit. Page 1 partment of portant: If i / injury or of		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee MOO217			ONSVILLE, MD FUNERAL HOME, P.A.
B	permi Depar Impo any ir		23a-Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	8521 LOCH RAVEN BLV	D. TOWSON	
C	Physician/ Medical Examiner		Immediate Cause (Final	nonary Arrest	-	Onset and Death
09	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undership Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of cause)			
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3		23d. Date of delivery Month Day Year
ls, P.O.	uires that the signed by ald be deta	ed by PI	Part II. Other significant conditions contributing to death but not resulting in metabolic Encephalopath			use contribute to the cause of death? $\c No 3 \square$ Probably $\c 4 \square$ Unknown
Division of Vital Records,	The law requate has been page 2 shou	Completed by	End Stage Renal Disease, Ci un controlled Dia betes		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No
Vital	hysician: his certific I director,	To Be (	25. Was case referred to medical examiner?  1  Yes 2  No  Hospital: 1  Nnpatient 2  ER/Ou		only one) me 5 □ Residence 6	i □ Other (Specify)
ion of	ttending P death. tor: After the	Certificate:	2 Accident Investigation	njury work?  M 1 □ Yes 2 □ No	28d. Describe how injury	
Divis	spital or Ai ours after ieral Direc filled in by	cal Cer	4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, or		City or Town, State	
	To the Hos within 24 h To the Fun	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination and/o only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowl 29b. Signature and title of certifier	r investigation, in my opinion, death occurred at	the time, date and place e, and due to the cause(s	, and due to the cause(s) and manner state
	)		30. Name and address of person who completed cause of death (Item 23a) (1	Resour	8-	7 2011
	Sta	te	Dr. Sundaram Chettias 9000 31. Date filed (Month, Day, Year) - 32. Distrar's Signature -	Franklin Square D	rive Bosti	more, MD 21237
	Registr	ar	AUG 1 0 2011 Acres A	harles		

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last. 2. Date of Death Physician/ Month **DABROWSKI TADEUSZ** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Glen Burnie Anne Arundel Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min OI OZ 213 06 7106 58 Poland **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 748 Powhatan Beach Road 21122 Poland 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify. 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 is in and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Windows and Doors Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Waclaw Dabrowski Krystyna Zwierz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 1455 Gordon Dr. Glen Burnie, 21061 - Wife MDElzbieta Dabrowska other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 108/09/11 Baltimore, Holy Cross Cem 22. Name and Address of Facility GJ Gonce Funeral 21. Signature of Funeral Service Licenses Pasadena, 169 Riviera Drive MD 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami death certificate be executed and tran that initiated events resulting in death) Last Due to (or as a consequence of) nding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death 9 Unknown Hospital or Attending Physician: The law requires that the signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed certificate 2 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA မ this funeral Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 5 Pending injury work? 1 🗌 Yes 2 🗌 No after death Director: A I in by the fi Accident Investigation 6 Could not be within 24 hours after dex

To the Funeral Director

completed filled in by th Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8-4-11 1)443 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21061 Glen Burnie, MD MD 301 Hospital Dr. Kasamon,

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

AUG 10

			1 - State State Registrar	of Maryland /		rtment of H			giene Reg. No. 20		25444	
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	Year	3. Time of Death	
	Medic Examir	cal	Lloyd Eugene Darla  4a. Facility Name (if not institution, give street and no			4b. City, Town, or I	ocation of Dea	August	8 20	1 Pear of Death	1:00pM	
· Marcolan	Exami	CI	2 Virginia Avenue			BelAi			Harford			
	Funeral Director		5. Social Security Number 6. Sex 1 X M 2 - F	7. Age (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir				lace (State or Foreign iv) NSAS	
	and show lat	o.	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tov	wn or Loc	ation				1	0d. Inside City Limits	
	Maryla 28a-f	Director	Maryland Harford		В	elAir					1 Yes 2X No	
	vith the 23a or st be n		10e. Street and Number  2 Virginia Avenue			10f. Zip Code <b>2101</b>	1		10g. Citizen of W	/hat Coun	try?	
	eath w	Funeral	11. Marital Status 12. Was De	cedent Ever in U.S.		/as Decedent of His Yes, specify Cuban	panic Origin? (S	Specify Yes or No-	14. Race	- Americ		
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 ★ Married   Armed   1 ★ Married   1 ★	s 2 No 1943	_	Yes 2 XNo		to ficall, etc.)		white, e		
15-	72 hou n "natı fedica	nplet	15. Decedent's Education (Specify only highest grade complete	d)	(Give k	ent's Usual Occupa ind of work done du NOT use retired)		orking	16b. Kind of Bu	isiness Inc	lustry	
212	within rgiene. ner thai		Elementary/Seconday (0-12) College	(1-4 or 5+) <b>4</b>		ivil serv	ice		U.S.	Gove:	rnment	
Maryland	oe filed intal Hy ced oth c event	To Be	17. Father's Name (First, Middle, Last)  Leroy Darland					ame <i>(First, Middl</i> e, a Butche		)		
ary	should be file n and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print)	19	9b. Mailin	g Address (Street ar				tate, Zip C	Code)	
Š.	and 2 s Health s em 27 i		Lois B. Darland (wife) 20a. Method of Disposition			rginia Av	enue, B					
nor	age 1 age 1		1 ☐ Burial 2X Cremation 3 ☐ Removal fro	m State cemet	tery, crem	sition (Name of atory or other place		Date 9/2011	20c. Location - West Ch	•		
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1		21. Signature of Funeral Service Licensee	10 Ma	22	Name and Address	of Facility				rdeen, MD	
			23a. Part 1. Enter the disease, or complications the								Approximate	
-35	Ph_sician/		shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition	1x-terios	Scle	rotic 1	Heart	Dise	WE		Interval Between Onset and Death	
Spenson's	Medical Examiner		resulting in death)  Dul t	o (or as a consequence	e of):						— <b>y</b> .	
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	o (or as a consequence	e Jiji					8		
	ecuted and I-transi	Examine	Cause (Disease or linjury that initiated events c.  Due to (or as a consequence of):									
09	icate be executed g physician and is the burial-transit	edical	d									
	ertificat ding ph	/Med	IF FEMALE: 23c. If yes. c	utcome of pregnancy								
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	in the past 12 months?	e Birth 2 🗌 Fetal dea egnant at time of death	h 2  Fetal death 3  Ectopic pregnancy t at time of death 5  Other (specify)					23d. Date of delivery Month Day Year		
s, P.O	requires that the despect bear signed by the signed by the should be detached	d by Pi	Part II. Other significant conditions contributing to	death but not resulting	g in the u	nderlying cause give	en in Part I.	23e. Did to	1		e cause of death?	
ord	iw requise been 2 should	Completed by	Obesity					24a. Was autor			osy findings available mpletion of cause of	
Rec	The la		J					perfo	rmged2	leath?	•	
Vital	/sician s certifi director	To Be	25. Was case referred to medical examiner?  1  Yes  No  Hospital:	☐ Inpatient 2 ☐ ER/0	Outpatien	Othor	ce of Death (Ch	eck only one)  Home 5 Resid	tence 6 1 Othe	er (Specify	)	
Division of Vital Records,	ing Phy After thi uneral o		27. Manner of Death 28a. Da		. Time of injury	28c. Injury work?	at		now injury occurre		/	
isior	Attend r death ector: A	Certificate:		ce of Injury - At home,	farm, stre		∕es 2 □ No	28f. Location (S	Street and Numbe	er or Rural	Route Number,	
Ω	urs after ral Dir		bul	ding, etc. (Specify)				City or Tow				
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2:	Medical	29a. Certifier (Check 2 Medical Examiner: On the bounds only one) 3 Certifying Nurse Practione	asis of examination and	l/or invest	gation, in my opinior	n, death occurred	d at the time, date a	ind place, and due	to the car	use(s) and manner stated	
	Vithi Vom	_	29b. Signature and title of certifier	1 000	N D	29c. License	number	354	29d. Date signed	(Month, I	Day, Year)	
	•		30. Name and address of person who completed ca	use of death (Item 23a)	(Type, P	rint) - 2 - C	007	0 1	n wyw:	V (	1 2 mad	
			31. Date filed (Month, Day, Year) 32.	1055 W	'D'	1305	Day VI	+ KONO	rallsto	on) lx	10. 21071	
	Sta Registr		AUG 1 0 2011	James Signature	ho	ale						

llaye Dunlavel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25445 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:36 AM Sandra Lee Evans 2011 MGUST Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A BALTIMORE CITY HOSPITAL UF BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In vrs. last birthday) 1 M 2 X Months Hours Min 09714/1955 Maryland 55 **Director** 218-58-9417 Usual Residence of Decedent or 28a-f show be notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Randallstown MD Baltimore Co. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 and 0,00e. Funeral 5005 Old Court Rd. 21133 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Rep. Super Media years Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruben DaShield Doris Mondell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Evans III(son) 5005 Old Court Rd., Randallstown, MD 21133 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1x Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cem. 08/17/11 Baltimore, MD 21. Signature of Funeral Service License Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 unno 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician LUPUS ERYTHEMATOSUS SYSTEMIC Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or se a consequence of, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 mo ths?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should k 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy erformed? r this certificate haral director, page 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: ျာ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director; A

completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 AUGUST 9, 2011

Registrar
DHMH 17 Rev 7/2009

2

State

SANORA SANORA

KNOKY

2401 W. BELVEDERE AVE.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. JOSHI

BRIJEN

31. Date filed (Month, Day, Year)

AUG

MD

Registrar's Signat

11-05898								
Kinaya Easton								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 1 1 25446
State of Maryland / Department of Health and Mental Hygiene

•		1- For State Certificate of Death Registrar Certificate of Death		eg. No.	
Physic Medical Exam		1. Decedent's Name (First, Middle,Last) Kaneya Chanell Alexes Easton -Kinaya Chaenl Lexus Easton	2. Date of Dea Month August 6,	Day Year	3. Time of Death 1051 hrs
-		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of		4c. County of Deat	
Funeral		University Hospital Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	24Hrs 8 Date of Bi	N/A th(MM/DD/YYYY) 9. Bi	rthnlace (State or
Director		317-53-6934 1 M 2XF 1 month Yrs. Months Days Hours Usual Residence of Decedent	Min. 6/29/	Forei	
r any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show	ţ	MD N/A Baltimore			1 X Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Il Director	529 N. Carrollton Ave. Apt. 1 21223	1	0g. Citizen of What Cou USA	intry?
ig P	y Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No specify:		White, etc.	Black
hours a natura Examir	ed by	15 December 1 Februaries (Consideration Consideration Cons		16b. Kind of Business	'Industry
36 in 72 l	Completed	Elementary/Secondary (0-12)  N/A  N/A  N/A  N/A	ise retired)	N/A	
5-00 ed with stygiene other 1	Com	17. Father's Name (First, Middle, Last) 18.Mother's	Name (First, Middle,	•	_
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Theodore Easton Sh	irley R.	Fulton	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af Department of Fleath and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	2	19a. Informant's Name/Relationship (Type, Print)  Shirley R. Fulton-Mother  529 N. Carrollt			
re, N 1 and 1 Health Fitem		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, bermit. Pages I an Department of Hee important: If itel			3/13/2011	Lansdown	, MD
Balti permit. Departm Imports injury o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Ave. Balto.,	March E	/H 1101 E	. North
Physician	(, I) 12°	23a. Part I. Engel the disease, or complications that caused the death, Do not enter the mode of dying, such as ca	MD 21202 rdiac or respiratory arr	est, shock, or heart	Approximate Interval
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a. Sudden Unexplained Death in Infance			Between Onset and Death
ممد		or condition resulting in death)  Due to (or as a consequence of):	- <sub>1</sub> (00D1)		
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
31	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):			
ecuted and transit		d		•	
760, icate be ex physician the burial	Medical	▼ UNPENDED	13-11 sm		
5876 rtificat ling ph		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	pregnancy	23d. Date of deliver Month	y Day Year
Box 68' death certiff	Physician/	1  Yes 2 ✓ No 9 Unknown 9 Unknown 9 Unknown	1		
O. B. at the de d by the tached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	I. 23e. Did to	obacco use contribute to	the cause of death?
s, P.O ires that t signed by d be detac	d b		1 Yes	s 2 <b>✓</b> No 3  pro	bably 4 Unknown
cords law requi	Completed		24a. Was autop	sy prior to	utopsy findings available completion of cause of
tal Rec tian: The li certificate h	S		perfo 1 <b>✓</b> Yes	med? death? 2 No 1 Y	es 2 No
of Vital Records, ng Physician: The law require ther this certificate has been si neral director, page 2 should b	å	25. Was case referred to medical examiner?  1 ✓ Yes 2 No   Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other 1 DOA Other 2 → Company Compan	Check only one)  Nursing Home 5	Residence 6 Othe	
of V ing Phy After th	٩	1 ✓ Yes 2 No 1 inpatient 2 ✓ EROutpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?		now injury occurred	
ion ttendii death. ctor: /	atio	Natural 5 Pending Accident Pending Investigation Fd 8-6-11 Fd 10:00 am 1 Yes 2x 1	√ Unknow	n	
Division of Vital Records, P.O. Box 68760, 24 Hospital or Attending Physician: The law requires that the death certificate be executed Functs after detector. Functal Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	Suicide  4 Homicide  6 X Could not be determined  Could not be determined  Specify) Residence	28f. Location (sor Town, S	Street and Number or Ritate) 529 North altimore, Mo	Carrollton
To the Hosy within 24 hc To the Fun completely i	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the caus	e(s) and manner as stat	ted.
H 3 H 3	W	29b Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
DE S		( a fut our O.C.M.E.		August 7, 2011	
Low		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	ore, MD 21223		
- St. /	_	31. Date filed (Month, Day, Year)			
Regis		AUG 1 0 2011 Ann S. Soul			
DHMH 17 Rev 1/2	UU1	ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 25447 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 20 1°1 Earls 3:30 Рм Corrine May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Aberdeen 1905 Bruce Road 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 /11 /1 935 1 M 2 X F 76 Virginia 227-44-0581 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Aberdeen MD Harford 1 Yes 2 XNo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21001 Funeral 1905 Bruce Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Nursing 12 Laundry Supervisor and Mental Hygier is marked other traumatic event, Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Maxfield Georgie Crusenberry permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 Mitchell Lane, Aberdeen, MD 21001 Timothy Osborne / 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 8/10/2011 4 Donation 5 Other (Specify) Cemetery Aberdeen Baker 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A 333 S. Parke St. Aberdeen, MD 2 1001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit and attending physician Physician/Medical death certificate be P.O. Box 68760 the SS IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ò Month Day Year Pregnant at time of death the detached signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performed? Yes 2 XNo certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to hedical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) 2 No 1 Yes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No Investigation Accident filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 29b. Signature and title of certifie 29c. License number Date signed (Month-Day, Year) who completed cause of death (Item 23a) (Type, Print 30. Name and addr State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Ma	ryland / [		rtment of H <i>tificate of D</i>		d Mental	Hygien Reg. N	ZUII	25448
	sicia		Decedent's Name (First, Middle, Lass     Michael Francis	Fitzpatri	ck		_		2. Date of Month Augus		3 <sup>ay</sup> 2 <sup>Vea</sup> 1	3. Time of Death 9:42 A M
	ledic amine	er	4a. Facility Name (if not institution, give	street and number)			4b. City, Town, or			4	c. County of Deal	
Fune	eral		Montgomery Genera  5. Social Security Number 6. Social Security Number	ex 7. Age	(In yrs. last birti	hday)	Oln If Under 1 Year	If Under 24 H	rs. 8, Date o	f Birth	Montgome g. Bir	thplace (State or Foreign
Direc	_		214-52-2781	<b>X</b> ] M 2 □ F	63	Yrs.	Months Days	Hours Mi	Mar Mar	Day, Year	948 Was	hington DC
land show	ğ	. I	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town	or Loca	ation			-		10d. Inside City Limits
e Mary	notifie	Sirec	Maryland Montgom	ery			Silver	Sprin	g	10- (	Division of MAI at Oc	1 Yes 2 X No
death with the Maryland items 23a or 28a-f sho	st be	Funeral Director	10109 Lorain Aven	116			209	901			citizen of What Co ited Sta	
ING Z1Z13-UU30 filed within 72 hours after death with the Maryland tal Hygiene.  do other than "natural", or items 23a or 28a-f show	ner m		11. Marital Status	12. Was Decedent Ev Armed Forces?		13. W	as Decedent of His Yes, specify Cubar	spanic Origin?	(Specify Yes or erto Rican, etc.	No- )	14. Race - Ame Black, Whit	
USO s after ral", o	Exami	ed by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates.	10	1	Yes 2 🔀 No	Specify:			Specify: W	nite
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land 21215-UU36 be filed within 72 hours after lental Hygiene. ked other than "natural", or	the M		Elementary/Seconday (0-12)	College (1-4 or 5+	_	iiie. DO wne:	NOT use retired)			R	ofing E	usiness
and e filed ital Hyg	event	To Be	17. Father's Name (First, Middle, Last)						Name (First, Mi			
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t, MG nd 2 sh ealth a m 27 is	er tra			ghter			East Can			oenix	, AZ 850	118
DOFE ge 1 ar nt of H	or oth		20a. Method of Disposition 1 ☐ Burial 2 😿 Cremation 3 ☐	Removal from State	cemeter	ry, crem	ition (Name of atory or other place		Date		Location - City or	•
Baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot	/ injury	1	4 ☐ Donation 5 ☐ Other (Special Service License)		inal Jo	_	ey Cremat					Maryland
	an on		Deveryof He	chiotte	MO1251					_	arksvill	784 e, MD 21029
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he dear	ched to	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 U Pregnant at 9 Unknown	time of death	5 🗆	Other (specify)				WOILI	Day Four
s that the	oe deta	<u> </u>	Part II. Other significant conditions of	ontributing to death bu	it not resulting i	in the ur	nderlying cause giv	en in Part I.				the cause of death?
require been si	pinous	eted								1 ☐ Yes Was an		Probably 4 Unknown utopsy findings available
VITAI KECOLOS,  ysician: The law requires lis certificate has been sig	age 2 s	Completed		<del></del>					_	autopsy performed? Yes 2	prior to	completion of cause of s 2 No
cian: T	actor, p	Be	25. Was case referred to medical examiner?	Hospital:			041-	ace of Death (C		700 171		
OT VI	eral dir	일	1 Yes 2 No  27. Manner of Death	1 Mnpatie 28a. Date of injury		Time of	28c. Injury	4 ∐ Nursin ≀at			6 Other (Specury occurred	cify)
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DIVISION tal or Attendir s after death. al Director; Af	in by 1	Certi	4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, fa (Specify)	ırm, stre	et, factory, office			ion (Street a or Town, Sta		iral Route Number,
To the Hospital or Attending Physician; The law requires that the death certific within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending in the funeral physician of the funeral physician death of the funeral physician death of the funeral physician death of the physician death of the function o	ed filler	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	sician: To the best of r	ny knowledge, amination and/c	death o	ccured at the time,	date and place	e, and due to t	ne cause(s)	and manner as st	ated. cause(s) and manner stated.
o the Point 24 of the Point 24 of the Point 25	ощріет	₩	only one) 3 Certifying Nur 29b. Signature and title of certifier	se Practioner; To the b	est of my know	ledge, d	eath occurred at the	e time, date and	l place, and due	to the caus	e(s) and manner as Date signed (Mont	stated.
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3	,		30. Name and address of person who					MID 30	1814			
	Stat	e	Alex Kinginh 31. Date Flag Gonth, Day 2021	32. Registra	Signature	LP D	r. Onley	, FID 20	7014			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25449 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ August Dау 6. 2ď11 10:45 A M Jacqueline G. Ferguson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Gilchrist Howard County If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Auq 25, Pennsylvania 1936 Director 135-32-0531 74 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Columbia Maryland Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 10135 Goodbody Court 21044 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ruth Wagner Walter E. Gess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4219 Sugar Pine Ct. Burtonsville, MD 20866 David Bruce Ferguson / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 8/11/2011 Woodbine, Maryland Journey Crematory Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ lung COIC COIL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for selection of our to Examin Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Year Month Dav Pregnant at time of death the 9 Unknown To the Hospital or Attending Physician: The law requires that the Records, P.O. ed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has lirector, page 2 s autopsy performed? Yes 2 No 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \to \) Nursing Home 5 \( \to \) Residence 6 \( \times \) Other (Specify) 1 🗌 Yes 2 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28c, Injury at work? 1 □ Yes 2 □ No 28b. Time of Certificate: 28d. Describe how injury occurred in 24 hours after death.

the Funeral Director: After inpleted filled in by the funer. 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F

complet only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 12 Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMNO (Month, Day, Year) 32. Registrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 555 AM August 2011 reemai Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 15 altimore tospital INOI If Under 1 Year If Under Social Security Numbe 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** 1 □ M 2 🗹 Hours Conth Day, Year) Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10d. Inside City Limits Town or Location Director 1 Yes 2 No 5TOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No Specify: 3 ₩idowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Be Freemar ၉ Informant's Name/Relationship (Type, Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Vimore MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Foneral Service Licensee MD 21/33 Part 1. Inner the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death 23a. Part 1. Immediate Cause (Final Physician/ Acute on chronic renal failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner nephrectomu Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine gastrointestinal bleed contributing Cause (Disease or linjury and that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) the attending physician Physician/Medical certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death jo in the past 12 months? Month Day Year signed by the at d be detached for 2 No Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pertension, congestive heart Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an diabetes wellitus has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr 1 Yes 2 No Yes 2 3 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Hospital 2 No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) r of Death 27. Man 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could pot be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated RESONC G,2011 dress of person who completed cause of death (Item 23a) (Type, Print) Sivai Kristine State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25451 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0805 Roland Frazier August 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. (Month, Day, Year) Country) 1 ▼ M 2 □ F 215-28-8907 **Director** June 10. 1020 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c, City, Town or Location Director 1 Yes 2 HoNo MD Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6504 Carroll Highlands Road 21784 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 1. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates. ģ 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4X Divorced Completed Korea 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Tool Fabrication 8 Tool & Dve Maker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ William O. Frazier Mamie Easton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mrs. Linda DeFlavis (Niece) 9110 Ramblebrook Road, Baltimore, MD 21236 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Lake View Mem. Park 8/8/2011 Sykesville, MD 21. Signature of Funeral Service Licenses 22, Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 400764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complication; that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ intracerebral hemorrhage panietal tempora! disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated exercises. Examine Due to (or as a consequence on): and transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ atter in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Dav Year Pregnant at time of death the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has page 2 s 1 Yes 2 No certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ျ 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of funeral Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) August 4 2011 David Herst 101706

Registrar

State

Suite 12D

Bultimore, MD 21201

Greene St

Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2011

David Hersh

Year)

31. Date filed (Month, Day,

State

31. Date filed (Month, Day, Year)

AUG

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

Division of Vital

32 Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 25453 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jeanne Louise Fullwood 8:45A M 2011 Aug Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll 2341 Kays Mill Rd. Finksburg 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2X F Months Days Hours 6-24-1945 VA 216-42-5572 66 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Examiner must be notified one. 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Carroll Finksburg 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 2341 Kays Mill Rd. S 21048 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. **2** 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Yes 2X No Specify. Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service Rural Carrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Scott Lilly Leona Stefanek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2341 Kays Mill Rd. S, Finksburg, MD 21048 Rubin V. Fullwood-husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State South Carroll Crem 8-11-11 Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of uneral Service License 22. Name and Address of Facility Fletcher Funeral Home Z hemas 21157 E. Main St., Westminster, MD 254 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or a a consequer ce Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury physician and s the burial-trans that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Live Birth 2 Fetal death Month Day Year Pregnant at time of death signed by the a Yes \_\_\_ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 seconds. autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Nio Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Registrar DHMH 17 Rev 7/2009

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State

29a. Certifie

only one)

29b. Signature and title of certifier

32. Registrar Signa

1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 25454 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month 400m Physician Carrol J. 2, Harrison 2011 Auq. /Medical 4h City Town or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Genesis Hamilton Center Baltimore If Under 1 Yeer 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) Funeral Months 1**∑**M 2□ F 217-38-0690 70 Director Nov. 11, 1940S. Carolina Usual Residence of Decedent parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Plyglana. Important: If them 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, The Medical Examinar must be notified at 10a, Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at X<sup>1</sup> ☐ Yes 2 ☐ No N/A Directo Maryland Baltimore 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 4213 Elderon Avenue 21215 USA Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11 Maritel Status I ☐ Yes 2√☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: Completed by 3 ☐ Widowed ♣☐ Divorced Year or Dates: 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Private Industry 7th grade
17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jefferson Harrison Edna Askins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type, Print) Victoria Harrison/Daughter 4213 Elderon Avenue Baltimore, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 SeBurial 2 ☐ Cremation 3 ☐ Removal from State 8/10/11Pikesville,MD Druid Ridge Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Se 5240 Reisterstown Rd Baltimore, Maryland an 21215 Interval Between 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure, list only one cause on each line. Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as Physician/Medical Examiner inding physiclen end use es the burial-trensit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 □ Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No been signed the should be det þ æ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy perlormed? has 211No 1 ☐ Yes >2 No 1 ☐ Yes 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 No Other: 2 1 Tyes 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) th Is eral Director: After thi filled in by the funeral 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturel 1 □ Yes 2 □ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide hours after within 24 hours a
To the Funeral C
completaty filled 29a. Certifier edlcai 1🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature nd title of certifier d address of person who completed cause of death (Item 23a) (Type, Print) 30. Name a 31. Date filed (Month, Dey, Year) 2. Registrat's Sign State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 25455 Certificate of Death 1. Decedent's Name (First, Middle, Last) George Robert Hickman Jr. 2 Date of Death 3. Time of Death Physician/ Month R Hickman 0241 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** university of maryland medical Center Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 1 □ M 2 □ F Director 58 214-54-4607 MD Usual Residence of Decedent show or 28a-f shov notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD NA 1 🌠 Yes 2 □ No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? must be r Funeral 21223 U.S.A. 16 North Wheeler Ave "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14 Bace - American Indian Black, White, etc. b 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ¥ No Specify: Specify: Black Completed 3 Divorced 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2th grade life. DO NOT use retired) College (1-4 or 5+) Cleaning Company Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alice Burrell George Robert Hickman Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6 North Wheeler Ave, Baltimore, Md 21223 19a. Informant's Name/Relationship (Type, Print) Tajuana Hickman-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 8/11/2011 Woodlawn, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Sign Funeral Service Licensee Baltimore, 21215 -Md Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part Approximate Interval Between Immediate Cause (Final Onset and Death Hepatocelluar Caranoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

o the Funeral Director: After this certificate has performed 2 1 No 2 No 1 Yes ompleted filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 NO 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5  $\square$  Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225. Greene St. orie Grant Barmore, MD 21201 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25456 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mugust 20T1 10:30pm м Robert Mark Higgs Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospital Center Westminster Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Nov. 2, Year 951 1 🛣 M 2 🗆 F Hours 59 MD **Director** 217-48-0054 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 XNo MD Carrol1 Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1599 Homeland Drive 3D 21784 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ò 1 Never Married 2 XMarried Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Towson State University College (1-4 or 5+) Project Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Floyd Russell Higgs Willodean Wilt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda K. Higgs (Spouse) 1599 Homeland Dr. 3D Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Lake View Mem. Park Burial 2 Cremation 3 Removal from State 8/11/2011 Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA M00764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence oi) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day been signed by the a should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) M D33681

DHMH 17 Rev 7/2009

State Registrar 1380 Progress

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

			For State Registrar	State of Maryla		artment of F tificate of <u>E</u>		Mental Hy		2011	25457
	Physicia Medi		Decedent's Name (First, Middle, Las	Howard Ro	obert Ha	arryman		2. Date of De Month August	eath Day 8	$2\overset{Year}{011}$	3. Time of Death 15 45 P M
	Examir		4a. Facility Name (if not institution, give	street and number)			Location of Death	_	$\neg$	County of Death	
-	Funeral		Carroll County Ge 5. Social Security Number 6. Se		a1 . last birthday)	Westmin	ster If Under 24 Hrs.	8. Date of Bi	rth a	Carrol	lace (State or Foreign
	Director		220 24 3407	M 2 □ F 81	Yrs.	Months Days	Hours Min.	(Month, Pa	ay, Year)	930 MDoun	place (State or Foreign try)
	show dat	  -	Usual Residence of Decedent  10a. State 10b. Counfy	10c. C	City, Town or Lo	cation				1	0d. Inside City Limits
	Maryla 28a-f etified	irect	MD Carroll	M	It. Airy	7					1 ☐ Yes 2 ☐Xio
	ith the 23a or st be n	Funeral Director	10e. Street and Number 5168 Perry Roa	đ		10f. Zip Code 21771			10g. Citi	izen of What Coun	itry?
	eath w tems	Fune	11. Marital Status	12. Was Decedent Ever in L	J.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	pecify Yes or No-		14. Race - Americ	an Indian,
36	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Completed by	1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Very Yes 2 No 19  If Yes, Give 10	/	Yes, specify Cuba		o Rican, etc.)		Black, White, e Specify: whit	
5-00	hour natu lical	olete	15. Decedent's E. (Specify only highest gra	ducation	16a. Deced	lent's Usual Occupa	ation	lda a	16b. Ki	ind of Business Inc	dustry
121	s filed within 72 hour tal Hygiene. ed other than "natu event, the Medical	Som	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. Do	kind of work done d O NOT use retired)		King	NSA	Λ	
d 2	iled wi I Hygie other ent, tl	Be	17. Father's Name (First, Middle, Last)	2	logis	stics spe	C1aL1St 18. Mother's Nar	ne (First, Middle,	. Maiden S	Surname)	<del></del>
ylan	should be filed within 72 o and Mental Hygiene. 7 is marked other than " raumatic event, the Mec	우	Howard E. Harryma	n			Mary E.			· · · · · · · · · · · · · · · · · · ·	
, Maryland 21215-0036	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		19a. Informant's Name/Relationship (Ty Margaret Harryman	*	19b. Mailin 5168	g Address (Street a Perry Rd	., Mt. A	ral Route Numbe iry, MD	er, City or 2177	Town, State, Zip C 71	Code)
nore	age 1 ar ent of He nt: If iter y or oth		20a. Method of Disposition  1	Removal from State		sition (Name of natory or other place Forest V		Date _11		ocation - City or To	,
Baltimore,	permit. P Departme Importar any injur		21. Signature of Funeral Service Licens		22	. Name and Addres	s of Facility Ha	ight Fu	neral	Home &	
	T - 1 - 1 - 1 - 1	Н	23a. Part 1. Enter the disease, or comp	plications that caused the dea		O. Box 1				. /84	Approximate
	Physician Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consect b. Due to (or as a consect c. Due to (or according t. Due to (o							Interval Between Onset and Death
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	p ##	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consec	quence of):	1.41)	c . 1		,		
	ecuter and l-trans	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):	21713	CMIA			5/10	
200	cate be executed physician and s the burial-transit	edical Examiner	L	d			_				
687			IF FEMALE:	23c. If yes, outcome of pregn	nanov.						
Вох	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. In the form of the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🗀	Ectopic pregnancy Other (specify)	<del>/</del>			23d. Date of delive Month	ery Day Year
P.O.	es that the designed by the a	by Ph	Part II. Other significant conditions co	ontributing to death but not re	esulting in the ur	nderlying cause give	en in Part I.			se contribute to th	
rds,	require been sign	eted	USTEVENT	WITH AT OF	7			13			pably 4 X Unknown
3eco	he law r te has b age 2 sl	Completed							psy ormed?	prior to cor death?	osy findings available mpletion of cause of
talF	ding Physician: The k h. After this certificate h funeral director, page		25. Was case referred to medical examiner?				ce of Death (Chec	1 L Yes	2 X No	i i res	2 L NO
f Vii	Physic this corral dire	မ	1 ☐ Yes 2 🗶 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 28a. Date of injury	ER/Outpatien		4 ☐ Nursing H			Other (Specify)	
o uc	nding ath. :: After e funel	icate	1 Matural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	28c. Injury work? M 1 🗆		28d. Describe	now injury	occurred	
Division of Vital Records,	or Atter	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specia	nome, farm, stre fy)	et, factory, office		28f. Location (S City or Tov		Number or Rural	Route Number,
۵	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical (	29a. Certifier 1 Certifying Phys	ician: To the best of my know	wledge, death o	ccured at the time,	date and place, a	nd due to the ca	use(s) and	d manner as state	d.
	the H thin 24 the F mplete		(Check 2   Medical Examir	ner: On the basis of examination of the basis of examination of the basis of the ba	nji knowlada je	eeth persunsel at the	time, data and pla	te, and due to the	ic causa(s)	tan.C. nanier az eta	ttsc.
	<b>5</b> ≥ 5 8		TANAPA	(5)	>	29c. License	3561		29d. Date	e signed (Month, E -19-2011	pay, Year)
		- 4	30. Name and address of person who con James L. Fox 1. Date filed (Month, Day, Year)  AUG 1 0 2011	ompleted cause of death (Iter	m 23a) (Type, F	rint)	(1) 4	, <b>Δ</b> Δ1	0 .	1/ 2011	(1) 2:-01
	Stat		James L. Fok	32. Registrar's Sin	3 <b>Y D P I</b>	of ress	vay #1	17, 51	acr's	syung, v	71784
97,	- Registra	ij. Iľs⊷	AUG 1 0 2011	Denne P	gar	ALC:					

11-05880

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

elicia Harris	State of Maryland / 1-For State Registrar	Department of Hea		giene Reg. No.	2011 2545
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Felicia Nicole Harris			2. Date of Death Month Day August 5, 2011	3. Time of Death 1439 hrs
P <sup>ri</sup> ty	4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center	4b. City Bel	, Town, or Location of Death	40	. County of Death Harford
Funeral Director	220-17-7774 1_M 2XF		nder 1 Year   If Under 24Hrs. https://doi.org/10.1006/	8. Date of Birth (MM/ June 8, 1	DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland
Aaryland 28a-f show any 1 at once. ector	Usual Residence of Decedent  10a. State	Oc. City, Town or Location Joppa			10d. Inside City Limits 1 Yes 2 No
nith the Maryland 123s or 28s-f sh 120s of 20s-f sh 120s	10e. Street end Number  206 Duryea Drive  11. Marital Status  12. Was Decedent E	2	Zip Code 1085 Ident of Hispanic Origin? (Spe	USA	zen of What Country?  14. Race - American Indian, Black,
Baltimore, MD 21215-0036  permit. Pages I and 2 should he filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at nonce.  To Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? 1 Yes 2  3 Widowed 4 Divorced If Yes, Give Year or Dates:	If Yes, spe	cify Cuban, Mexican, Puerto R  2X No specify:	ican, etc.)	White, etc.  Specify: White
5-0036 ed within 72 hour itygiene. other than "natu the Medical Exar Completed	15. Decedent's Education (Specify only highest grade comp  Elementary/Secondary (0-12)  College (1-4 or 5+  12	during most of v	al Occupation (Give kind of wo vorking life. DO NOT use retire	d) G	rocery Store
MD 21215-0036 d 2 should he filed within 7 d 2 should he filed within 7 or 7 is marked other than 10 or 10 is marked other than 10 or 10 is marked other than 10 or 10 o	17. Father's Name (First, Middle, Last)  Hubert Gene Murray  19a. Informant's Name/Relationship (Type, Print)	19b Mailing Addre	18.Mother's Name (I Peggy Ann ss (Street and Number or Ru		
e, MD 2  1 and 2 shou Health and I item 27 is refraumatic	Donald E. Harris Jr. / Husk	oand 206 Dury	ea Drive, Jopp	a, Maryla	
Baltimore, permit. Pages 1 ar Department of Hea Important: If itel injury or other tr	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Sig = Pre of Funeral Service Licensee	Cokesbury UM	C Cem. 08-0	omas Fune	ingdon, Maryland ral Home, P.A.
Physician /Medical	23a. Par I. Enter the disease, or compliations that caused the failure. List only one cause on each line.	ne death. Do not enter the mod			n, Maryland 21009  ck, or heart Approximate Interval Between Onset and Death
≛xaminer	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,  a Narcotic In Due to (or as a consequence).				55001
ted Insit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cons				
e be executed ysician and burial - transit		27,28a-f,per m	e,g918 8-12-11		
D. Box 6876( I the death certificate by the attending physiched for use as the b Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ✔ Unknown  23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at tir 9 ☐ Unknown	2 Fetal deat			l. Date of delivery Month Day Year
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Physical direction	examiner? 1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 1 Natural 5 Pending fd 8-5-1	r)	DOA Other Nursing  28c. Injury at Work?  27		nce 6 Other:
Division of Bospital or Attending 24 hours after death. Funeral Director: After after the funeral principled in by the funeral all Certification:	4 Homicide determined (Specify)	ry - At home, farm, street, facto Residence	ry, office building, etc.	Bf. Location (Street and or Town, State) 2 (	nd Number or Rural Route Number, City Of Duryea Dr.
2 1 2 5 5 5 L	29a. Certifier 1 Certifying Physician: To the best of my k one) Medical Examiner: On the basis of examiner and manner stated.  29b. Signature and title of certifier	nation and/or investigation, in r		he time, date and pla-	
	30. And and address of person who complete cause of dea		O.C.M.E.		ust 6, 2011
0.0.0	Laron Locke MD. Assistant Medical Exam  31. Date filed (Month, Day, Year)  32. Referrers		re Street, Baltimore, MI	21223	· · · ·
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DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MUGUST 3ay 201 gar WILLIAM C. INGRAM 2:25pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL 8621 FLUTTERING LEAF TRAIL APT 203 ODENTON 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 XM 2 - F Months Days Hours 12-12 1ay, 1eg 54 New Jersey Director 145-50-6307 56 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No ANNE ARUNDEL MD. ODENTON 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8621 FLUTTERING LEAF TRAIL APT 203 21113 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 🖾 No Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", BLACK 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) -3-Elementary/Seconday (0-12) -12-SENIOR ACCOUNT ACT WIRELESS EXECUTIVE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ELLA R. BIRKHEAD JAMES INGRAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21113 VANESSA GARRETT-INGRAM(WIFE 8621 FLUTTERING LEAF TRAIL APT 203 ODENTON 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ADAMS U.M. CHURCH CEMETERY 4 ☐ Donation 🔰 ☐ Other (Specify) 8-6-2011 LOTHTAN, MARYLAND 21. Signature of Funeral Service Licensee HARRY REESE 22. Name and Address of Facility WILLIAM REESE & SONS MORTUARY, PA 1922 FOREST DR. ANNAPOLIS MARYLAND Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Immediate Cause (Final OPHIC Physician/ LATERAL SCIERUS AMYOTE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a nonsequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death Other (specify) 2 No Yes 9 Unknown this certificate has been signed by the aral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death?
1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be ( funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending Acciden Accident Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the it 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse/Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only o PROF. Signatu 29d. Date signed (Month, Day, Year) NEUROLOGY 0006 who completed cause of death (Item 23a) (Type, Print) NEUPOLO GT MARTE Year) State AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 25460 Certificate of Death lent's Name (First, 2. Date of Death 3. Time of Death A Month Physician/ 8:30P rson 6,2011 Medical tugust **Examiner** give street and number) or Location of Death 4c. County of Death Baltimore Avenue Birthplace (State or Foreign Country) **Funeral** last birthday) 8. Date of Birth (Month, Day, Year) Director f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f timore 1 ¥Yes 2 ☐ No ö 10f. Zip Code 10g. Citizen of What Country permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 21229 11. Marita Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 31 Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Shoreman Be ပ္ 19b. Mailing Address (Street and Number or Rulal Route Number, City 20b. Place of Disposition (Name of demetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ure of Funeral ervice Licetse 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 0 Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ral a consequent of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Dilli to for as a nonsequence off: Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year /these hed fo Pregnant at time of death 2 No Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? 0 certificate 1 Yes Yes Vita 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? 2 No 1 Tes Other: 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpa 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes Certificate: 28b. Time of 1 Natural 28d. Describe how injury occurred 5 Pending injury 2 🗌 No ☐ Accident Investigation 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 071188 e and address of person who completed cause of death (Ite 0 31. Date filed (Mo AUG State Registrar

11-05885 Ronald Jackson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar  Certificate of Death	gierie Reg.	201	1 2546
Physici		1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
Medical Exam	iner	Ronald Melvin Jackson  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	Month D. August 5, 20	111	2056 hrs
		4a. Facility Name (if not institution, give street and number)  St. Josephs Hospital  4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore Cou	
Funeral	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth(	MM/DD/YYYY) 9. Birt	
Director		216-78-0129   1xm 2 F   52 Yrs.   Months Days Hours Min.	01/22/	1959 Foreig	n untry) MD
Å		Usual Residence of Decedent			
DW ABY		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits  1 Yes 2 No
Maryland 28a-f show d at once.	ctor	MD N/A Baltimore 10e. Street and Number 10f. Zip Code	I 10a	Citizen of What Cour	<b></b>
ith the Maryland 23a or 28a-f sho notified at once,	Director	2204 Glander I A Andr A	log.	U.S.A.	iu y ?
3 72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	匝	3301 Clarks LA Apt A 21215  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Ameri	can Indian, Black,
death r iten	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto R	Rican, etc.)	White, etc.	
rafter	by F	3 Wildowed 4 X Divorced or Dates:		Specify: Bla	
15-0036 filed within 72 hours aft I Hygiene. so other than "natural" t, the Medical Examine.				b. Kind of Business/I	ndustry
	Completed	4 years Collection Man	ager /	ALW Source	rina
5-00 ed wit Hygien other	Son	17. Father's Name (First, Middle, Last)  18. Mother's Name (first, Middle, Last)	_		29
2 5 E F E	Be		e Jacks	son	
	ပု			-	
md 2 sho calth and tem 27 is		Beatrice Ward (mother) 3419 Reisterstown  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		LC1MOre,  Oc. Location - City or	
Baltimore, permit. Pages I ar Department of Heckin portant: If ite injury or other tr		1 XBurial 2 Cremation 3 Removal from State crematory or other place)			
Itim nit. Pa artmen ortani	4	4 Donation 5 Other Specify: Garrison Forest 08/ 21 Signature of Funeral Service Licensee , 22 Name and Address of Facility wn			
Dep Dep Inju	U	Dietrich N. Williams 2140 N. Fulton A	ve., Ba	altimore,	MD 21217
Physician	7.7	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r failure. List only one cause on each line.			Approximate Interval Between Onset and
`/Medical ≞xaminer		Immediate Cause (Final disease a Cardiac Arrhythmia			Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions  Myocardial Hypertrophy, and Hypertensive Cardiovas	1 D!	_	
	Jer	if any leading to immediate  Due to (or as a consequence of):	scular Dis	ease	
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
ecuted and transit	Ë	events resulting in death) Last Due to (or as a consequence of):  d.			i i
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760, icate be exphysiciar the burial	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	- I	23d. Date of delivery	
Box 687 death certific the attending p	cian	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnance 4 Pregnant at time of death 5 Other (Specify)	У	Month D	ay Year
BOy e death the att	Physician/	1 Yes 2 No 9 Unknown 9 Unknown			
P.O. s that the gned by e detach.	by P			co use contribute to t	
S, P.C	8				ably 4 Unknown
ords aw requi as been : 2 should	pet		24a. Was an autopsy	prior to co	opsy findings available empletion of cause of
tal Records, cian: The law requir certificate has been s ector, page 2 should b	Completed		performed Yes 2	i? death? No 1 ✔ Yes	2 No
ician: certif	a	25. Was case referred to medical 26. Place of Death (Check onleaning)			
ing Physing Physuneral di	P	Tes 2 NO	Home 5 Res	idence 6 Other:	
Division of Vital Lal Or Attending Physician is after death.  al Director: After this certical in by the funeral director.	Ę	1 X Natural 5 Pending (Month, Day, Year)		many boodings	
ViSion Attender de Directo	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28			al Route Number, City
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Functal Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	4 Homicide determined (Specify)	or Town, State	) 	
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and du one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.			
To the within 2 To the Complete	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number		d. Date signed (Mon	. ,
		O.C.M.E.	l l	ugust 6, 2011	, Day, 18ar)
_	1	30. Name and address of person who completed cause of death (Item 23a)			
		Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD	21223		
St Regist					
- AND COL		LINE TO CALL MANNE TO MANNE			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend#6perfn g918 8-11-11 d.o. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician/ Lremer Day 6 an Medical 4anFacility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Deat 4c. County of Death Genesos Jeverna rark na 5. Social Security Number 8. Date of Birth (Month, Day, Ye Feb. 14, 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Days Min. 1 M 2 XF Hours Year) Maryland **Director** 212-24-8170 1926 85 Usual Residence of Decedent 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🗌 Yes 2 🗎 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 1527 Shore Side Trail 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates Ith and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical | 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Dorn Mary Hamme1man permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Stately Drive, Pasadena, Md. 21122 (Son) <u>Kenneth M. Kremer</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 8/12/1/1 Sacred Heart Of Jesus Cent 21. Signature of Fundal Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nal Va4cul evel disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Be Completed by Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? elimato1 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown OSTEOMYELITES Jacrum 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy andany performed? Yes 2 No USPhagia 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the heat of my knowledge, death produced at the flare, date and place, and due to the cause(s) and ma was as stated 29c. License number **F**(**7**(**7**) **3 94**(**1**) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUNI LEV H CLANK M & 2007 Tidewater Colony Dr. # 1 A. Annapales MD 2149 State Registrar

Please Type or Print/in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pauline C. Kochevar 2011 August 6:10A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Keswick Multi Care Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Discourse (Month, Day, Year 31 **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 219-22-2453 1 □ M 2 🂢 F 90 Hours Country) Director 1920 Pennsylvania August Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? 700 West 40th Street 21211 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. the Medical Examiner ŏ þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. "natural", Completed 3 X Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 land Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Cuturilo Marko Anna Karaffa Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark F. Kochevar 1963 Krameria Street, Denver, Colorado Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CorpusChristiCemetery 8-12-11 Dunlo, Pennsylvania 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licer 6009 Harford Road, Baltimore, Maryland marguelle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final 1 Neumonia Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by demenna 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 1 ☐ Yes 2 ☐ No Hospital Other: 일 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Nelle ,2011 35102 august Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMOR MAM LAND DON 5901 NothCH mes rut m.D. 31. Date filed (Month, Day, Year) State AUG 1 0 2011 Registrar HMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20h per fh 918 8-19-11 vt. State of Maryland PDepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Larkins 02:04 AM **Physician** Brandy 05 August 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 8. Date of Birth 02/16/1982 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Maryland 1 □ M 2√2 F 216-98-0302 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Co. Gwynn Oak 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 1ry or other traumattc event, the Medical Examiner must be in Funeral I 1627 Ingleside Ave. Apt 12 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes \_ 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Residence Care Eden Wald 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Larkins Latashya Ervin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Latashya Ervin(mother) 1627 Ingleside Ave., Gwynn Oak, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of Lorral menaperative Centle tery 20c. Location - City or Town, State Important; If its any Injury or o once. Department of 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Mt. Zion Cemetery 08/16/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Jöseph Anges Brown Jr. Funeral Home PA 21. Signature of Funeral Service Licensee 2140 N. Fulton Ave., Baltimore, MD 21217 retich N. Williams 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Honormal disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Postpartum physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical rdio useu IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☑ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy 4 Pregnant at time of death
9 Unknown in the past 12 months? Month 5 Other (specify) 1 XYes 2 □ No 9 □ Unknown 2011 August 04 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 No 1 Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) al or Atten...
urs after death.
eral Director: After this ce
Ay filled in by the funeral di 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral C completely filled Hospital 6 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D0067523 Hugust 05,2011 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sings/er BriAn 4940 Eastern Avenue, Baltimore, MD, 21224 M.P. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25465 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Derrell Gene Lane Physician/ Month Year August 2011 8:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 615 Waterwheel Lane Millersville Anne Arundel Social Security Number Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 🕅 M 2 🗆 F 444-36-3175 71 Yrs Director /1940 New Mexico Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified a Millersville MD Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 615 Waterwheel Lane #12 21108 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent Ever in U.S.
Armed Forces?
1 Styles 2 □ No Army
If Yes, Give 1 9 6 1 − 6 5
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Transportation Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Malden Surname) ဂ္ Eulice Lane Eunice Alexander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 WEaterwheel Lane, Millersville, 19a. Informant's Name/Relationship (Type, Print) Rosemary S. Lane Wife #12 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1  $\square$  Burial 2  $\textcircled{\textbf{X}}$ Cremation 3  $\square$  Removal from State 8/11/2011 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. Woodbine, MD Signature of Funeral Service icensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final metistatic disesse Onset and Death Physician/ with ung ancor disease or condition Medical resulting in death) Due to (or as - snsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin -trans and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DCA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director. Afte completed filled in by the fune 5 Pending 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie H 46961 VNO

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign ture

Salome Hawkins- Wile, D. O.

31, Date filed (Month, Day, Year) **AUG 10 2011** 

Heartland Hospice, 4 E Rolling (Nissouls

Catonsville,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 25466 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Monti **08** 0 Day 2011 Helen Anna Ledzinski 7:42 AMM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2101 Alfonsas Drive Carroll Westminster Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Hours (Month, Day, Year) 1/09/1931 **Director** 218-32-8674 79 Maryland Usual Residence of Decedent show 10a. State within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2101 Alfonsas Drive 21157 U.S.A. "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 X Divorced Specify: Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Greater Baltimore Elementary/Seconday (0-12) College (1-4 or 5+) the 12 4 Registered Nurse Medical Center or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Anthony Tremper Elizabeth R. Koch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ren'e Pachuta (daughter) PSC475 Box 1891 - FPOAP96350 - Japan Department of Heall Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 N Other (Specify) Entonoment Air Memorial Gdns.08/11/2011 Bel Air, Maryland atur of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause each line 4therosclerohe Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine tany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence of: attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 1 Natural injury 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hin 24 hours a the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifier 29c. License number 052035 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 291 Warmenter 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Denous W DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State		State of IV	iaryian		riment of P tificate of D	ieaith and iv Death		gierie Reg. No.	0 ! !	0-1
			Registrar  1. Decedent's Nam	e (First, Middle, Last	t)					2. Date of Dea	ath C	Year	3: Time of Death
	Physicia Medic			LLIAM V						August			9:50P <sup>M</sup>
	Examin	er		not institution, give s w Nursing					Location of Death		Ba	ounty of Death 1timore	e
	Funeral Director		5. Social Security N 237 28 953	. [	х М 2 🗆 F   7. Ас 94		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt February	<sup>th</sup> <b>28</b> <sup>r)</sup> 19:	9. Birth Mc£ea	place (State or Foreign Shsville, N.C.
	how at	'n	Usual Residence of 10a. State	Decedent 10b. County		10c. City	y, Town or Loc	ation					10d. Inside City Limits
	Ra-fsl	recto	Maryland	Baltimore		Balti	imore Co	unty					1 🗆 Yes 2 💆 No
	with the N	Funeral Director	10e. Street and Nur 5001 King					10f. Zip Code 21237				en of What Cou SA	intry?
2	Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Then to Health and Mental Hygiene. The math; if them 27 is marked other than "natural", or items 28a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1  Never Mari	ried 2 X Married 4 Divorced	12. Was Decedent Armed Forces? 1 💢 Yes 2 L If Yes, Give Year or Dates.	No No		/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 🔀 No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		. Race - Ameri Black, White, pecify:	
5	2 hours "natur edical I	Completed	(Spe	15. Decedent's Ed ecify only highest grad	lucation	WW II	(Give k	ent's Usual Occupa	ation during most of worki	ing	16b. Kind	d of Business Ir	ndustry
7	ithin 7; ene. r than the Me	Com	Elementary/Sec		College (1-4 or N/A	5+)	ife. DO Machini	NOT use retired)			Glenn	L. Mart	in
2	filed wall Hygi dother	Be	17. Father's Name						18. Mother's Name		Maiden Su	rname)	
ı yıa	d Ment marke matic	To	William S	May ame/Relationship (Ty	ne Print)		10h Mailin	a Address (Street	Mary Carte		r City or To	own State Zin	Codel
N N	d 2 sho alth an n 27 is er traui			Ford (Daught			5001 K	ing Avenue	and Number or Rura Rossville	, Md. 212	237	wii, otato, Eip	
altilliore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once.			position  Cremation 3   5   Other (Specify		20b. P	lace of Disposemetery, crem wood Cem	sition (Name of latory or other place etery Augl	üst 10 2011	Date		ation - City or 1	
Dall	permit. Departr Imports any inju	(1)	21 Signature of Fu	neral Service Videns	20h	0			ral Home In Boad Baltim		/land 2	21236	
	rnysician Medical Examiner		shock, or hea Immediate Cause disease or condition resulting in death)		olications that cause ne cause on each ling a	Der	h. Do not ente	r the mode of dyin	g, such as cardiac c	or respiratory ar	rest,	73.0	Approximate Interval Between Onset and Death
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death.  within 24 Hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	al Examiner	Sequentially list or if any, leading to ir cause. Enter Unde Cause (Disease or that initiated event resulting in death)	nmediate erlying injury ts	cDue to (or as							. 29	
	ficate t g phys as the l	Medical	ie eeuw e		d								
חל אמם	death certi	Physician/M	IF FEMALE:  23b. Was decedent in the past 12 1 ☐ Yes 2  9 ☐ Unknowr	months?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2  Feta at time of c	aldeath 3 📙	Ectopic pregnand Other (specify)	эу 		23	3d. Date of deli Month	very Day Year
5	that the ned by e detacl	by Ph		ficant conditions co					ven in Part I.			_	the cause of death?
Ď,	equires sen sign	ted k	1	Park	infon	,2	pise	ose					obably 4 Unknown
ממפנים	Physician: The law re r this certificate has be aral director, page 2 sh	Completed										prior to c death?	opsy findings available completion of cause of
9	sician: certific rector,	Be	25. Was case referrexaminer?	- H	Hospital:		50/0-1	Oth	ace of Death (Checker:		C.	7 Oath an (Sana)	£.)
5	iding Phys th. After this funeral di	cate: To	27. Manner of Deat  1 Natural 2 Accident		28a. Date of inj (Month, Da	ury	ER/Outpatien 28b. Time of injury	28c. Injury work	y at (? Yes 2 \( \) Nursing Ho	28d. Describe			ту)
NIVISIO	of or Atter after dea Director d in by the	Certificate:	3 Suicide 4 Homicide	6 Could not be	28e. Place of In	jury - At ho tc. <i>(Specif</i> y		eet, factory, office		28f. Location ( City or Tox		Number or Rur	al Route Number,
	e Hospita n 24 hours e Funeral	Medical	(Check 2	Certifying Phys	ner: On the basis of	examination	n and/or invest	igation, in my opinio	on, death occurred a	t the time, date	and place, a	and due to the c	ause(s) and manner stated.
	To the vithin To the comp		29b. Signature and	4 /	2- 1	0.0		29c. License	e number 3 5 5 9 3		29d. Date	signed (Month	O / /
				ress of person who c	U LO	H	1 23a) (Type, P	rint) +Macs	2 Ave	Bal	10.	MD	21221
	Stat Registra		31. Date filed (Mon	th, Day, Year)		rar's Signa	ture						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State 25468 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 AUGUST WILHELMINA M. MILLER 8:30P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **EMERALD ESTATES** BALTIMORE BALTIMORE CITY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Ye Aug. 2, **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Min. Director 214-12-2620 Maryland 90 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Maryland Baltimore City Yes 2 No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3855 Greenpring Ave. 21211-3301 Unit 110 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married ģ Maryland 21215-0036 SpecifyWhite If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th 1<u>2th grade</u> Office Worker N/A Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marvel T. Crump Marie Eva Wirth permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic to 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce C. Mitchell(Nephew) 1415 Sparks Rd. Sparks, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ¹XX Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 8-12-2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 22. Name and Address of Facility Lassann Funeral Home signature of Fun ral Service Licensee 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ andiovascular Disease Atherosclerotic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, If any, leading to immedic cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year been signed by the should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe anem 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2  $\square$  No after death ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 128987 8-9-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPERLING 5601 LUZH RAVEN BLUD BALTO, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 0 2011 Registrar

DHMH 17 Rev 7/2009

			State of Maryland / Dep 1-State Registrar Amend Items 23a per dr.,g91	artment of Health and Annihicate of Death	Mental Hy	giene Reg. No. 2011	25469
н	Physici	an	1. Decedent's Name (First, Middle, Last)  Joseph H. Mettle, Jr.		2. Date of De Month	eath 30, Day 2011	3. Time of Death 12:00 P M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 619 Tanglewood Dr.	4b. City, Town, or Location of Dea		4c. County of Dea	
	Funeral Director		5. Social Security Number 215-30-8776 6. Sex 1 M 2 F 7. Age (In yrs. last birthday Yrs.	If Under 1 Year   If Under 24 Hr   Months   Days   Hours   Mir		rth ay, Year) 9. Bi	rthplace (State or Foreign ountry) ryland
aryland	show	-	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or L	ocation			10d. Inside City Limits
the M	28a-f	Director	MD Carroll Eldersbu	10f. Zip Code		10g. Citizen of What C	1 □ Yes 2 No
th with	23a or	al Di	619 Tanglewood Dr.	21784		United Sta	
d 21215-0036 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, Its Medical Exp. it at must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1  ☐ Yes 2 ☐ No 1953—  If Yes, Give  Year or Dates: 1957	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 □Yes 2 ☑ No Specify:	Specify Yes or Norto Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
<b>215-0</b> hin 72 ho	e. an "natur Medical I	Completed	15. Decedent's Education 16a. Dece	edent's Usual Occupation be kind of work done during most of wo DO NOT use retired)	orking	16b. Kind of Business	/Industry
21 led wit	lygien her tha		12th Comm	unication Enginee		Nation Se	c Agency
rlanc	dental F rked ot tic ever	To Be	17. Father's Name ( <i>First, Middle, Last</i> )  Joseph H. Mettle, Sr.	18. Mother's Na Frances	· ·	, Maiden Surname)	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft	ealth and N 27 Is ma er trauma			ng Address (Street and Number or Fanglewood Dr. Eld			Zip Code)
more, Pages 1 g	nent of He nt: If item ry or othe			osition (Name of matory or other place)  Memorial Park 8	Date 3/2/2011	20c. Location - City or Sykesville	
Balti.	Departrr Importa any Inju once.		21. Signature of Freeral Services General	2. Name and Address of Facility 1 <b>rrier-Queen</b> Fune 212 W. Old Libert	ral Home	and Crema	tory, P.A.
			3a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardia	ac or respiratory a		Approximate Interval Between Onset and Death
//	ysician Medical aminer		disease or condition resulting in death)  a. Due to (or as a consequence of):	UTC Liver Cance	r	<del></del>	1 brokyr
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events	Carcinoid			5 years
od/bu, cate be executed	physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last   C				
oo/ou, ifficate be ex	g physic as the bi	edical	d				
the death cer	To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ysician/Me		Ectopic pregnancy Other (specify)		23d. Date of de Month	olivery Day Year
ecolos, Palaw requires that	en signed b uld be deta	ed by Phys	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		tobacco use contribute t	o the cause of death?
The law re	cate has be	Completed			24a. Was auto perfo	psy prior to death?	utopsy findings available completion of cause of
V ILE	certifi	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Othor	eath (Check only o	one)	
ding Phy	After this funeral di	tion: To	27. Manner of Death	f 28c. Injury at Work?		dence 6 □Other (Spe how injury occurred	ecify)
l or Atten	Director: d in by the	ertification: T	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		28f. Location ( City or To	Street and Number or R wn, State)	ural Route Number,
e Hospita	e Funeral	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place westigation, in my opinion, death occ	Dee, and due to the curred at the time,	cause(s) and manner a date and place, and du	as stated. e to the cause(s)
To th	<b>То th</b> соттр	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)
			Menther	D68865		8/1/2011	
+1)			30. Name and address of person who completed cause of death (Item 23a) (Type, Kevin Cheung, MD 600 N. Wolfe St. Ba	ltimore, MD 2128	7		
	Stat Registra	e	31. Date filed (Month Day, Year) 2011 32. Registrar's Signature	Ke			

DHMH 17 Rev 1/2001

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		Funeral		5. Social Security N	lumber	6. Sex	7. Age	(In yrs. Ia	st birthday)		er 1 Year		r 24 Hrs.	8. Date of	of Birth		g. Birth	place (State or Foreign
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August 5,2011 4	2 2	permit, rage 1 and 2 should be made when it 2 hours aren dealt with the waryand begattent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp		3 🗆 Removal from	n Ctata		lace of Disp emetery, cre	osition (Na	ame of			Date		c. Location		
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3	E	Medical Examiner		resulting in death)		Due to	(or as	ull	lence ot):		013							
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2 ×	ath ce	attend for us	Physician/Medica	23b. Was decedent in the past 12, 1 Yes 2		23c. If yes, ou 1 🔲 Live 4 🔲 Pre	Birth 2	2 🗀 Feta	Ideath 3	Ectopio		У					ate of deli onth	very Day Year
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ORRISO ords Po Bo	The law requires that the death	been signed by the should be detached	<u>م</u>	Part II. Other signif	ficant condition	ons contributing to	death bu	it not res	ulting in the	underlying	g cause giv	en in Par	t 1.	23e.	Did tobac			the cause of death?
More	requir	been should	letec											24a.	Was an		Were aut	opsy findings available
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	or Att	after death.  Director: A in by the fu	Certi	4 Homicide	determ	inod 28e. Plac		ry - At ho (Specify	me, farm, st	reet, facto	ory, office				tion (Stree or Town, S		oer or Rur	al Route Number,
	the Hospital or Attending Physician:	within 24 hours after death.  To the Funeral Director: After the completed filled in by the funeral	Medical			Physician: To the												ted. ause(s) and manner stated.
	the H	within 24  To the Fi	Me		Certifying	Nurse Practioner				death occ		e time, da			e to the ca		nanner as	stated.
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E 11	,			30. Name and addr	ress of person	who completed cau	use of de	ath (Item	23a) (Type,	Print)	<del>/                                    </del>	110	107	TIL	dollar	IM	UN	71092
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 4c per doc g918 8-10-11 vt
State of Maryland / Department of Health and Mental Hygiene State
Registrar Reg. No. Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month S Marie Murray 0 0/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore <del>-USÀ</del> Alice Manor Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. 1 1 / 2 4 / 2 2 Country, 214-18-1334 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director N/A MDBaltimore Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2095 Rockrose Ave 21211 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status African þ 1 Never Married 2 Married ☐ Yes 2 🛣 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Amer. 3

Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hospital filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housekeepimg permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other t any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ unk unk 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Mae Williams 22 Cedar Heights Court #C, Balt., MD 212 07 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Garrison Forest 1 KBurial 2 Cremation 3 Removal from State Owings Mills,MD 4 Donation 5 Other (Specify) 22. Name and Address of Facilit Hari P. Close F.Svs, PA 5126 Belair RD, Balt., MD 21206-5105 21. Signature of Service Licensee unera 23a. Part 1. enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. thewsclerotic Cardiovescula Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to ministrate cause. Enter Underlying Examine Due to for sele consequence of as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical certificate be 68760 IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Fetal death in the past 12 months? j Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 ANO To the Hospital or Attending Physician: The lywithin 24 hours after death.

To the Funeral Director: After this certificate h Yes 2 1 🔲 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: ٩ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No Natural injury 5 Pending Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical National Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-Even 821 AOA 31. Date filed (Mont AUG 1 0 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25472 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 8 12:10PM Physician/ 60 201 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) WASHINGTON MEDICAL **Examiner** BURNIE ANNE CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Sex 1. M 2 □ F Virginia **Funeral** Days Hours Min 2352 86 24 226 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fen 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified a once. 10c. City, Town or Location 10a. State Director 1 Yes 2 X No MD Anne Arundel Orchard Beach 10g. Citizen of What Country? 10e. Street and Number Funeral 21226 U.S.A. 8222 Highpoint Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗆 No 1943 – If Yes, Give 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chem Metals Corp Shipping and Receiving Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ္ဝ EMILY DUNCAN LEWIS MINOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand-21060 6701 Whitewater Ct Glen Burnie, MD Angela Schwarzel - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 08/08/11 Glen Burnie, MD Glen Haven Mem Pk : 4 Donation 5 Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home, Signature of Uneral Service Licenses Pasadena, 169 Riviera Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** CHOLANGITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner use as the burial-transit PANC that initiated events resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months Month Pregnant at time of death 2 No 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a Was an prior to completion o death? autopsy performed 1 Yes 26. Place of Death (Check only one) To Be 25. Was case referred to predical examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29d. Date sign od (Morfth, Day, Year) 29b. Signature 8 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie, 21061 Tarak Reddv 301 Hospital Dr. MD31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201T 1:10am Mildred Ruth August Oakman Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Allegany Western Maryland Medical Center Cumberland Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours July 16, Year) 1942 Country) 1 □ M 2 👿 F MD 69 Director 212-40-6757 Usual Residence of Decedent or 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21244 USA 8538 Dogwood Road 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: d Mental Hygiene. marked other than "natural", Specify. 3 Widowed 4 Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Credit Counselor Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o ဂ Charles E. Grill Mildred E. Hartung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8538 Dogwood Road, Baltimore, MD 21244 Mr. Carlton Oakman (Spouse) injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation 8/6/2011 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licens PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complicated is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician) OCD! disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death been signed by the attendin should be detached for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy death? 1 🗌 Yes 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 140 Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suic' 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Dav. Year) un ce MD 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Hills Scule 101 Kawa Year State

T DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25474 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Colleen Elizabeth Pace Month 20<sup>Year</sup> 9:56 AM August Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9 Birthplace (State or Foreign Funeral 1 - M 2XCXF Months Days Hours Month, Day, Year) 109/1930 213-22-6950 Director 81 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Berlin MD Worcester 1 Yes X X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 9930 Orchard Road 21811 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married <sub>Specify</sub>White If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ld be file Mental I ၉ Cyress Florida Simpson Byrne Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If Item 27 is lucille Pace Mitchell 8425 Cedar Lane Rd., Berlin, MD 21811 Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey crem. 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 8/11/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Semice Licenseorona Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition 124 DULUMONI Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> ace (c) |con C 554 ⊃ Division of Vital Records, 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 2 🗌 No Yes Yes 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month.

Day, Year)

AUG

01/169/1930

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Gertrude H. Pardoe 5:00 A M August 4 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1893 Poplar Ridge Road Pasadena If Under 1 Year If Under 2 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 216-30-6014 Months Days Hours 1 M 2 X F Oct 18, 1932 Director 78 Maryland Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10d Inside City Limits 10c. City. Town or Location Director Pasadena 1 Yes 2X No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1893 Poplar Ridge Road Funeral 21122 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. þ 1 Never Married 2 X Married Yes 2 X No Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Anne Arundel County th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) School Teacher Board of Education 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo L. Horsmon ဂ္ဂ Emma Grierson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Lawrence W. Pardoe, Jr. (Husband) 1893 Poplar Ridge Road, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Glen Burnie. Marvland 8/6/2011 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial Park Signature of Funeral Gervice Licensee Kevin E Fcker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eson Physician/ Weeks Medical resulting in death) Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death 1 Yes 2 9 Unknow the 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🗹 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate 1 Yes 2 No \_ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred ieral Director: After filled in by the funer 1 Natural 2 Accider 5 Pending Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified

Registrar
DHMH 17 Rev 7/2009

State

tospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

305

		1 - State of Maryland / Dep	partment of Health and I ertificate of Death	Mental Hygiene Reg. N2011 25476
Physicia		Decedent's Name (First, Middle, Last)  M. Virgine Kathleen	Pugh	2. Date of Death Month Day Year  3. Time of Death
Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Funeral		The Villa  5. Social Security Number  6. Sex 1 □ M 2 🕅 F  7. Age (In yrs. last birthday,		8. Date of Birth 9. Birthplace (State or Foreign
Director		217-18-1965	Months Days Hours Min.	December 26,1923 County Maryland
aryland a-f shor fied at	Director	10a. State   10b. County   10c. City, Town or L   Maryland   Baltimore   Baltim		10d. Inside City Limits 1 □ Yes 2 🏹 No
n the Ma a or 28a be notif	I Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
eath with ems 23 r must	Funeral	6806 Bellona Ave.  11. Marital Status 12. Was Decedent Ever in U.S. 13	21212  Was Decedent of Hispanic Origin? (Sp	United States  ecify Yes or No-  14, Race - American Indian,
after de al", or it xamine	by	1 X Never Married 2 ☐ Married   Armed Forces? 1 ☐ Yes 2 X No   If Yes, Give	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	Black, White, etc.  Specify: white
2-005 2 hours aff "natural",	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of work	16b. Kind of Business Industry Of the
within 7 giene. er than the Me		Elementary/Seconday (0-12) College (1-4 or 5+)	po NOT use retired) rch ministry	Sacred Mission Helpers <sub>Heart</sub>
be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) George Pugh	ı	ne (First, Middle, Maiden Surname) Ne Feeley
The, INTRI YIGHTU ZIZIO-0000  I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  If man and Mental Hygiene.  If marked other than "Hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at.			ling Address (Street and Number or Rui	ral Route Number, City or Town, State, Zip Code) TOWSON, MD 21204
permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 20b. Place of Disp		Date 20c. Location - City or Town, State
permit. Page 1 Department of Important: If if any injury or once.		4 Donation 5 Other (Specify) New Cathe		10,2011 Baltimore, Maryland
Denmi Depar Impo any ir		yearu v. Truccinea	ou york ka. Ba.	Funeral Home, Inc. Ltimore, MD 21212
Physician/		23a. Pall 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	ential as cardiac	or respiratory arrest, Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)  a. Due to (or as a consequence of):		
sit sit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or linjury)  Due to (or as a consequence of):  Cause (Disease or linjury)		
or Attending Physician: The law requires that the death certificate be executed for detection. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	l Exal	that initiated events c.  Tesulting in death) Last  Due to (or as a consequence of):		
icate be p physic is the bu	ledical	d		
ath certific attending p	Physician/M	If the past 12 mounts?	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery  Month Day Year
that the des	Physic	9 Unknown		
v requires that been signed should be de	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e, Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
law requ has beer e 2 shou	Completed			24a. Was an autopsy findings available prior to completion of cause of
ician; The la certificate ha ector, page 2		25. Was case referred to medical	26. Place of Death (Chec	performed? death?  1  Yes 2  No 1 Yes 2 No
hysicia his certal direct	To Be	examiner? 1	ent 3 DOA Other: 4 Nursing H	ome 5 Residence 6 Other (Specify)
nding F ath. r: After t	Certificate:	27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation ☐ 28a. Date of injury (Month, Day, Year) ☐ injury	of 28c. Injury at work?  M 1 □ Yes 2 □ No	28d. Describe how injury occurred
l or Atte after de Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred a	t the time, date and place, and due to the cause(s) and manner stated.
To the within To the comple	∑	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	29c. License number	20d Date signed (Month Day Year)
2		30. Name and address of person who completed cause of death (Item 23a) (Type,	D43725	8/8/11 Westminster 2/157
d		TARIU MAITMUUD 19,1 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Vidge Road	Westminster 2/187
Stat Registra	~	31. Date filed (Month, Day, Year)  32. Registrar's Signature  AUG 1 0 2011		

			For State Registrar	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death Reg. No. 20 1 254							25477				
3	Physicia	n/	1. Decedent's Name (First, Middle	e, Last)	) ,			_	_		2. Date of De Month	ath Day	y Y	'ear	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution		mber)				Location o		08		County of		1 0.10 AM
77.	Funeral		2910 Greenway  5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Unde	r 1 Year	City If Under 2	24 Hrs.	8. Date of Bir	th	oward	9. Birthp	place (State or Foreign
	Director		213-20-7979 Usual Residence of Decedent	1 <b>∑</b> M 2 □ F	90	Yrs.	Months	Days	Hours	Min.	Sept 6	19; Year)	20	Coun	China
	nyland I-f show ied at	ctor	10a. State 10b. County MD Howar			City, Town or Lo		7						- 1	10d. Inside City Limits 1 ☐ Yes 2 【XNo
	the Ma a or 28a be notif	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citi	izen of Wha	at Cour	
	ems 23 r must	unera	2910 Greenway		edent Ever in l		Vas Deced	21042 dent of His	panic Orig	jin? (Spe	cify Yes or No-		USA 14. Race -	Americ	can Indian.
36	be filed within 72 hours after death with the Maryland ental tyygiene. Wed other than "hatural", or items 23a or 28a-f show ked other than "hatural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 【X Mar 3 ☐ Widowed 4 ☐ Divorced	. If Yes, Gi	2 □ No W ve	UTT '	f Yes, sper	cify Cuban	, Mexican,	, Puerto I	Rican, etc.)		Black, Specify:	White,	etc.
9500-91212	2 hours "natur? edical E	Completed	15. Decede	Year or D ent's Education est grade completed			kind of wo	rk done di	tion uring most	of worki	ng	16b. Ki	ind of Busin	ness In	dustry
1212	within 7 giene. er than ; the M		Elementary/Seconday (0-12)	College (	1-4 or 5+)	laund	o NOT use ry/di	,	eaner	OWI	ner	dr	y cle	ani	ng
and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Wei Wah Tom	Last)					18. Mothe		e (First, Middle, CO	Maiden S	Surname)		
Maryland	permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic ever once.		19a. Informant's Name/Relations				_				Route Numbe				
	of Health		Mr. Gary Pon (s 20a. Method of Disposition 1 X Burial 2 ☐ Cremation		20b	. Place of Dispo cemetery, cren	sition (Nar	ne of			Date		cation - Ci		
Baltimore,	iit. Page artment ortant: I injury or		1	Specify)	Cr	est Law	n Mer	noria	1 8	3-12-	-11 ght Fun				lle, MD
Ra	perm Depa Impo any i		Day Jay	1	rot						ville,			α	Спарет
	Physician)		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that only one cause on e	caused the de ach line.	ath. Do not ente	er the mod	le of dying	, such as o	cardiac o	r respiratory ar	rest,			Approximate interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	a. Oue to	(or as a conse	equence of):	11	4	mp	nce	na			+	3 years
		iner	Sequentially list conditions, if any, hading to immediate cause. Enter Underlying	b. Due to	(or as a conse	quence of):									
	cate be executed physician and the burial-transit	Examine	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to	(or as a conse	equence of):								+	
9	ate be e chysicia the buri	edical		d										$\perp$	
χ X X	death certific he attending I ed for use as	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, ou 1 ☐ Live	tcome of preg	nancy etal death 3	Ectopic	pregnancy	,			7/4	23d. Date		*
. Box	the deat by the att ached fo	Physician/M	1   Yes 2   No 9   Unknown	4 ☐ Preg 9 ☐ Unk	gnant at time o	ofdeath 5	Other (s)	pecify)					Month	1	Day Year
,	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	by	Part II, Other significant condition	ons contributing to	death but not r	esulting in the u	ınderlying	cause give	en in Part I		23e. Did t				he cause of death?
Records,	iw requir	Completed									24a. Was	an	24b. We	re auto	ppsy findings available ompletion of cause of
Ž Ž	n: The la ficate ha x, page		25. Was case referred to medical					QC Dia	ce of Deat	h (Ohnal	1 Tes	ormed?	dea	ath?	2 🗆 No
Vita	hysicia nis certi I directo	To Be	examiner? 1  Yes 2 100	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 🗆 D	Other	,		me 5 Resi	dence 6	Other (	(Specify	γ)
n ot	nding Path. ath. : After tl e funera	Certificate:	27. Manner of Death  1 Natural 5 Pendir 2 Accident Investi	ng 28a. Date (Morigation	e of injury nth, Day, Year)	28b. Time of injury	м 2	28c. Injury work?	at /es 2 🗌		28d. Describe I	how injury	occurred		
DIVISION	or Atte after des Director	Certif	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ained 28e. Place	e of Injury - At ling, etc. (Spec	home, farm, str hify)	eet, factor	y, office			28f. Location ( City or Tov			or Rura	l Route Number,
2	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2 Medical I		sis of examinat	tion and/or inves	tigation, in	my opinior	n, death oo	curred at	the time, date a	and place,	, and due to	o the ca	use(s) and manner stated.
	To the within 2 To the comple	Me	only one) 3 Certifying 29b. Signature and title of certifie	y Nurse Practioner:	: To the best of	my knowledge,		rred at the		and plac	e, and due to the		and mann te signed (//		
			- ffr	- 1 h	n Cu		Print)	V	38	76	2	•		-0	8-11
1			30. Name and address of person	70/0	20100	94	21,12	18 re	011	5-	Me C	Or ma	3 (/<		
	Stat Registra		31. Date filed (Month, Day, Year)		Registrar's Sig	nature	41								

DHMH 17 Rev 7/2009

			Please Type or Print in Black Indelible Ink. Ensure	All Copies A	Are Legible.	
			State of Maryland / Department of Health and	Mental Hygie	ene	05170
			1 - State Registrar Certificate of Death	Reg	9. NZUII	25478
	Physicia Media		1. Decedent's Name (First, Middle, Last)  Diane Charlotte Roberts	2. Date of Death Month August	Day Year 8 . 2011	3. Time of Death 7:14A M
	Examir		4a. Facility Name (if not institution, give street and number)  Shady Grove Adventist Hospital  4b. City, Town, or Location of Deat Rockville		4c. County of Death	1
	Funeral	,	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs.			hplace (State or Foreign intry)
	Director		Usual Residence of Decedent	05/21/		VA
	Maryland 18a-f sho tiffied at	Director	10a. State	own		10d. Inside City Limits 1 ☐ Yes 🏋 ☐ No
	s 23a or 2 s ust be no	Funeral Di	10e. Street and Number 11112 Flanagan Lane	10	g. Citizen of What Co	untry? SA
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates.  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 □ Yes 2 ☑ No Specify:	specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:Whi	e, etc.
21215-0036	72 hou in "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of wo	orking 16	6b. Kind of Business I	ndustry
212	within giene. ier tha t, the I	S	Elementary/Seconday (0-12)   College (1-4 or 5+)   Administrative Ass	istant	Office	
Maryland	I be filed fental Hy rked oth tic event	To Be		me (First, Middle, Mai Knight	iden Surname)	
Mary	d 2 should alth and N 1 27 is ma ir trauma		19a. Informant's Name/Relationship (Type, Print) Carl W. Roberts / Brother 76 Juicy Grape C	ural Route Number, Ci t • , Mart	ity or Town, State, Zip insburg	WV 25403
Baltimore,	Page 1 and ment of Hea ant: If item ury or othe	3	20a. Method of Disposition  1		Oc. Location - City or Woodbin	
Balt	permit. Depart Import any inj once.		21. Signature of Funeral Service Licensee Dorota Marshal 122. Name and Address of Facility  Maryland Cr PO NBox 141	emation	Services	21203
	Physician Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	•		Approximate Interval Between Onset and Death
	Examiner	_	Sequentially list conditions by Chronic liver failure			
	uted d ansit	Examiner	if any, Isading to immisulate cause. Enter Underlying Cause (Disease or iinjury that initiated events			
09	ite be exec hysician an he burial-tr	ल	resulting in death) Last  Due to (or as a consequence of):  d.			
. Box 68760	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The Luneral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit		FFEMALE:   23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1		23d. Date of deli Month	ivery Day Year
, P.O.	v requires that t s been signed by should be deta	l by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to	the cause of death?
ords	v requir s been s	oletec		24a. Was an	24b. Were aut	opsy findings available
Rec	The lar	Com		autopsy performe 1 \(\sum \) Yes 2 \(\frac{1}{2}\)	ed? death?	completion of cause of
tal	ician: sertific ector,	m I	25. Was case referred to medical examiner? Hospital: Cother:	eck only one)	(	
Ϋ́	Physi this cral dir	2	1  Yes 2  No Pospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at		ce 6 Other (Speci	fy)
Division of Vital Records,	tending leath. :or: After the fune	Certificate:	1 Natural 5 Pending (Month, Day, Year) injury work 1 Vest 2 No	28d. Describe how	injury occurred	
Divis	To the Hospital or Attending Physician: The law within 24 Hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s		4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	ne Hospi n 24 hou ne Funer pleted fil	Medical	29a. Certifier (Check only one)  1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, which is a complete that the time is a constant of the death occurred at the time, date and place, only one)  2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, only one)	at the time, date and p	place, and due to the o	ause(s) and manner stated.
_	To the Composite of the		29b. Signature and title of certifier 29c. License number	290	d. Date signed (Month	, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Brian carpenter, Mo 9901 Medien center Driv	e. Rockin	Up Mari	land 20800
0	Stat	-	Brian carpenter, MO 9901 Medical center UNIV 31. Date filed (Month, Day, Year) AUG 10 2011 Level Burley	1	7	
	Registra	r				

August 8,2011 0714

ROBERTS

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State of Maryland / Department of Health and Mental Hygien [

25479

			1 - State Registrar		C	ertificate of	Death		Reg. No.	
	D1		1. Decedent's Name (First, Middle	le, Last)				2. Date of De Month	ath Day Yea	3. Time of Death
	Physicia /Medic		SAMUE	L ALBERT RIT	TENHOUSE				8, 2011	9:10 A M
	Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town,	or Location of Deat	th	4c. County of D	
-88-			GILCHRIST HOS				son	1.5		re County
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthd	Months Days		(Month, Da	v. Year)	Birthplace (State or Foreign Country)
	Director		219-03-6996 Usual Residence of Decedent	X	93 Yrs			Sept 1	4, 1917 N	Maryland
	and		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Maryl f sho	ō	Maryland Balti	more County	Tor	son				1 □Yes 2 X No
	the l	Director	10e. Street and Number	more country	1Ow	10f. Zip Code			10g. Citizen of What	Country?
	3a or		1055 West Jop	pa Road.			21204		USA	
	ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 1	Was Decedent of If Yes, specify Cul		Specify Yes or No		merican Indian,
9	after or ite		1 ☐ Never Married 2 ☐ Marr	Armed Forces?	No 41-'46			to nican, etc.)		
5-0036	hours after death with the Maryland tural", or items 23a or 28a-f show al Examinar must be notified at	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	o Specify.		Specify:	White
ה	within 72 hours after death with the Marylan glene. r than "natural", or items 23a or 28a-f show the Medical Extrainer must be notified at	Completed	15. Deceden (Specify only higher	nt's Education est grade completed)	(G	cedent's Usual Occu	e durina most of wo	rking	16b. Kind of Busine	ess/Industry
2	within 72 iene. than "na"	ם	Elementary/Secondary (0-12)	College (1-4or 5	5+)	e. DO NOT use retir			DC + E	
N	illed value Hygie other t		17. Father's Name (First, Middle,	(1951)	Cnie	f Electri			, Maiden Surname)	Company
and	0 to 0	Be	Albert		enhouse		M.	Paul		land
>	should be and Menta marked umatic ev	은				ailing Address (Strac			er, City or Town, Stat	
Mar	2 s lar is		19a. Informant's Name/Relations Charles W. Har			-			re, MD 212	
	1 and Health tem 27		20a. Method of Disposition	(2021		sposition (Name of crematory or other plants		Date	20c. Location - City	
ē	Pages tment of tant: If it jury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			idge Ceme		/2011	Pikesvill	e, Maryland
altimore,	artme ortar injur		21. Sign tur of Jun rai Sen Age	-	Druru II		• .			
ñ	permit. Departi Importi any inj once.		Manne	Lawson		MITCHELL 6500 Yor	-wrederer k Road. F	D FUNERA Baltimore	AL HOME, I	NG. d 21212
			23a, Part 1. Enter the disease, or	r complications that caused	the death. Do not					Approximate Interval Between
	Physician	0.0	shock, or heart failure. List Immediate Cause (Final	only one cause on each li	ne.		14111			Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of):	MYOU	777			YEARS
	Examiner				,					
	D #	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter tonderlying Cause (Disease or injury	Due to (or as	a consequence of):					
8	nd ransi	Examine	that initiated events	c						
Ž	e exe ian a urial-t		resulting in death) Last	Due to (or as	a consequence of):					
)∳ ng/gg	ate b	Medical		d						
Õ	ertific ling p	Mec	IF FEMALE:	00.11						
g	atten atten for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal death	3 Ectopic pregnar			23d. Date of Month	delivery Day Year
j	he de	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of death	5 ☐ Other (specify)				
7.	that t ed by detac		Part II. Other significant condition	ons contributing to death b	out not resulting in th	e underlying cause g	iven in Part I.	23e. Did	tobacco use contribut	te to the cause of death?
Records,	uires sign d be	d by	ChRONIC OF	3 STRUCTIVE	PULME	VACY DIS	PASP	1 🗆	Yes 2 No 3 L	Probably 4 Unknown
2	v req beer shou	ete						24a. Was	an 24b Wer	e autopsy findings available
9	he lar e has ige 2	Completed						auto perfe	psy prior deat	r to completion of cause of th?
N I I a	ifficat or, pa		25. Was case referre medica	al .			26 Place of De	1 ☐ Yes eath (Check only		Yes 2 ŪNo
>	ysicia s cer direct	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatio	ent 2 □ ER/Outoa	tient 3 DOA	thor:		idence 6 Dother	Specify HOSPICO
DIVISION OF	g Ph er thi	n: To	27. Manne Death	28a. Date of Inju	ury 28b. Tim	e of 28c. Inj		<del></del>	how injury occurred	
<u></u>	ath. r: Aff	atio	1	ig .	ly, reary		□Yes 2□No			
<u> </u>	er der er der recto by th	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ningd   20e. Flace of Inj	ury - At home, farm, c. (Specify)	street, factory, office	9	28f. Location	Street and Number of wn, State)	r Rural Route Number,
5	tal on rs after all on all Dil	Certification:		9						
\	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical	ng Physician: To the best i Examiner: On the basis of	of examination and/o					
	the the mple	Medical	one) 29b. Signature and title of certifie	and manner st	ated.	29c Lice	nse number		29d. Date signed (M	fonth, Day, Year)
	F 3 F 3		March	Allon	1	$\mathcal{L}$	46360	,	1	C mark
•	6		30. Name and address of person	who completed course of	teath (Item 22a) /Tu	ne Print\	-000		10000;	8, 2011 Timore MV
	(1)		Will Har	Will completely cause of C	in MO	G70/n/	verte hi	rpies!	TED or BAI	Imerco MI
	Sta	te	31. Date filed (Month, Day, Year)	32. Registi	rar's Signature	14.140			1 6 91 2016	The state of the s
	Registr		AUG 1 0 2011	Burn &	. dorse					
_				1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2011 25

		-	For State Registrar	Otate of Me	ai yiai ia		ificate of L		vioritarity	Reg. No	2011	25480
Phys	iciar	1/	1. Decedent's Name (First, Middle, Last,						2. Date of De Month	ath Da	ay Year	3. Time of Death
	edica mine		Robert Ra  4a. Facility Name (if not institution, give s				4b. City, Town, or	Location of Death	Augue		. County of Dea	
-/- <u>-</u>			Johns Hopkins B 5. Social Security Number 6. Sec 214-36-7984	ayview M	edica	1 Center	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	l a Bir	thplace (State or Foreign
Fune Direc		L		X 2 D F	72	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) 939	Co	yland
and	10	_ r	Usual Residence of Decedent  10a. State 10b. County	T	10c. City,	Town or Loca	tion					10d. Inside City Limits
Maryla 28a-f		irect	Maryland Harford		Aber	rdeen			-			1 🔀Yes 2 ☐ No
with the	in ion	=	10e. Street and Number 22 Valley Bottom Re	oad			10f. Zip Code 21001			10g. Ci	itizen of What Co	ountry?
r death or item			11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1  Yes 2  T		13. Wa	as Decedent of Hi es, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	
2-0056  2 hours after "natural", o	T P	ted b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	NO	1 [	☐ Yes 2 🔀 No	Specify:			Specify: Wh	ite
in 72 holes.	Medica	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)			(Give kir	nt's Usual Occup nd of work done o NOT use retired)	ation furing most of wor	king	16b. k	Kind of Business	Industry
d withir sygiene	ii, iie	o l	7	0		Machine	e Operat				iry	
yland		- 1	17. Father's Name (First, Middle, Last)  Roman H. Ragan					18. Mother's Nan Beulah			Surname)	
d 2 should alth and N	naniia		19a. Informant's Name/Relationship (Typ Laura Ragan / Wife	ne, Print)				and Number or Rule tom Rd,				p Code)
perint. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 28a or 28a-f show minimum or the termine ones.			20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	20b. Plac R.A <sup>cen</sup>	ce of Disposit	tion (Name of tory or other place	8/9/	Date 2011	Wes	ocation - City or t Cheste nsylvan	er,
permit. Department.	once.		21. Signature of Tuner Stavice (Toe Se	.A. 21001								
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only on		Approximate Interval Between Onset and Death							
Physicia Medi			Immediate Cause (Final disease or condition resulting in death)	a. Res	pira	ce of:	Fail	ure				/ hour
Exami	-	ا ي	Sequentially list conditions.		nor							1 month
ted nsit		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a	consequer	nce of):						
ificate be executed g physician and as the burial-transit			that initiated events resulting in death) Last	Due to (or as a	consequer	nce of):						
ficate b		Medical		d								
Attending Physician: The law requires that the death certifica or death.  The death.  Substantificate has been signed by the attending provide function rade. Should be detached for use as its timeral director, nade 2 should be detached for use as its properties.		<b>≒</b> I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal d	death 3 🔲 l	Ectopic pregnanc Other (specify)	sy			23d. Date of de Month	elivery Day Year
Lires that the signed by ld be detacted	.	≥	Part II. Other significant conditions col	ntributing to death bu	ut not result	ting in the und	derlying cause giv	en in Part I.				o the cause of death? Probably 4 <b>Y</b> Unknown
The law requires cate has been signated as		Completed							24a. Was auto perfo 1 \sum Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of
ician: The certificate		g Re	25. Was case referred to medical examiner?	lospital:			100	ace of Death (Chec				
g Phys er this		<u>e</u>	27. Manner of Death	1 Inpatie 28a. Date of injun (Month, Day,	y 28	R/Outpatient 8b. Time of injury	28c. Injury	4 □ Nursing H ⁄at	ome 5 Resi 28d. Describe	. ——	6 COther (Sperry occurred	cify)
tendin death. tor: Aft		Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be				-	Yes 2 No				15 1 W
i ji ili		- 0	4  Homicide determined	28e. Place of Injur building, etc.	. (Specify)				City or To	wn, State	e)	ural Route Number,
To the Hospital within 24 hours of the Funeral I		Medical	29a. Certifier (Check only one)  1 Certifying Physical Examin only one)  1 Certifying Nurse	er: On the basis of ex	amination a	nd/or investig	ation, in my opinic	on, death occurred	at the time, date:	and place	e, and due to the	cause(s) and manner stated.
To the within 2 To the comple			29b. Signature and title of certifier	2			29c. License	number		29d. Da	ate signed (Moni	th, Day, Year)
		ŀ	30. Name and address of person who co		eath (Item 20	3a) (Type, Prir	nt)	>-00	0	MU	gust 6	07, 2011 e, Md, 21224
			Andrea C. E.	Baines 1	MD. P	CA	4940	Easter	n Avenu	ie B	altimor	e, Md, 21224
Reg	State istra		AUG 1 0 20	32.	s olgnatur	ba	Kel					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar 25481 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2011 Shirley Muir Swartwout August 7:30 A M 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death 8505 Springvale Terrace #237 Montgomery Silver Spring Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) If Under 24 Hrs. Days Hours 215-12-0528 1 🗆 M 2 🔀 F Usual Residence of Decedent 91 May 25, 1920 Illinois 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Maryland Montgomery Silver Spring 10e. Street and Numbe 10g. Citizen of What Country? Funeral 8505 Springvale Terrace #237 20910 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Takoma Park College (1-4 or 5+) 12 Public Library Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Keith Muir Teenie Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 180 Center Hall Rd. Cochranville, PA 19330 Robert M. Swartwout / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) inal Journey Crematory 8/9/2011 Woodbine, Maryland 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Hechrott MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death me laes c CONCO disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_

Physician/ Medical **Examiner** 

Department of Health a Important: If item 27 is any injury or other trains

Physician/

Medical

**Examiner** 

**Funeral** 

**Director** 

28a-f show notified at

ö

with

death v

hours after

Maryland 21215-0036

Baltimore,

ms 23a or must be r

er than "natural", or iter the Medical Examiner

traumatic

Hygiene.

should be filed with and Mental Hygien

Director

Be

2

nding physician a use as the burial-Box 68760 atter for t the Hospital or Attending Physician; The law requires that the P.O. ed by the signed a Records,

Division of Vital

s certificate has t director, page 2 s this n 24 hours after death.

e Funeral Director: After tholetely filled in by the funeral

Examine Physician/Medical þ Completed 25. Was case referred to medical Be ည Certificate:

within 2, **To the F** complet 0

Medical

State

Registrar

29a. Certifier (Check 29b. Signature and title of

5 Pending

Investigation 6 Could not be

determined

in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown

2 No

1 Yes

7. Manner of Death

Natural

2 Accident
3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Pregnant at time of death

Unknown

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of injury (Month, Day, Year)

1)0040948

Other:

1 Yes 2 No

28c. Injury at

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year)

24a. Was an

autopsy performed? Yes 2 No

4 Nursing Home 5 X Residence 6 Other (Specify)

28d. Describe how injury occurred

120

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 🗌 No

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2101 Medical Park Drive Ste. Julie Fox 301 Silver Spring, MD 20902

1 Inpatient 2 I ER/Outpatient 3 I DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

AUG 1 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3º11 1 od A M John Henry Sampson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Manor Care Falls Road Baltimore Funeral Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Days Min. 1 X M 2 🔲 I Months Hours Country) 7/25/1932 Director 79 S.C. 51-50-1445 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1 XYes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1239 N. Ellwood Ave. 21213 USA event, the Medical Examiner must and 2 should be filed within 72 hours after death v Health and Mental Hygiene. tem 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) MD Elementary/Seconday (0-12) College (1-4 or 5+) Brick Layer Brick Company 6th N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beulah Sampson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Phillips-Sister 1239 N. Ellwood Ave. Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 8/12/2011 GynnOak, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility  $March\ F/H\ 1101\ E$  . Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 3 CM D Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Disease or impury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-tran and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown ò s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 2 No 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one, Hospital: 2 No Other: 1 Yes 은 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA , Mannor of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 2 🗌 No Accident Investigation 24 hours after deatle Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) D0069814 087 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rs Parkelle Waltham Woods MD 21234 8813 Prajarati 32. Registrar's bignatura State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 25483 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8,2011 MILLARD HERMAN SMITH 1:28 p<sup>M</sup> AUGUST Medical 4a. Facility Name (if not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER TOWSON

4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min May 9. 1921 1 🗙 M 2 🗆 F Mary land 213-12-6268 Yrs Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Funeral Director Baltimore N/A Maryland 1. Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 1729 Patapsco Street 21230 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. WW 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status traumatic event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) A & P Co. 8 Grocer 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file.
Department of Health and Managarit: If item any injure. Joh n Smith ပ Mary Katherine Momberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2308 Wuthering Road, Lutherville, Maryland 21093 Lynn Smith-Reichhelm (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery Aug 12, 2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Signature of Funeral Service Licensee Kevin E Ecker 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death 2 days Immediate Cause (Final Physician/ Severe anemia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner al bleed 2 days Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate 10 days Septic arthritis / MRSA bacteremia Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No Yes 2 N To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Contributing Nurse Practice of Table 2 and 1 and 1 my knowledge shall occurred at the time date and place, and the cause (s) and manner to stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Renu Thomas,

AUG 1 0 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

MD

32. Registrar's Signature

6701 N. Charles

D60630

Street, Towson, MD

8/8/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 25484 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Seale Month Martha 201 8:43 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 319 West Riverview Road Social Security Number Funeral Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 225-30-9788 1 □ M 2 **K** F Min. Months 88 February 12", 1923 Virginia **Director** Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 319 West Riverview Road 21225 Ŭ.S.A. Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. 'natural", or Completed by Black White etc. 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 Yes White If Yes, Give 1 Yes 2 X No Specify Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done duning most of working life. DO NOT use retired) 27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Steven D. Young Victoria Doodley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Hudson 1508 Tieman Drive Glen Burnie, Maryland 21061 daughter item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Aug 6, 2011 Brooklyn Park, Maryland 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 237 E. Patapsco Avenue, Baltimore, MD 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EardioThrombotic event disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner cardiovasiular Disease Atheroscientic Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) detached for Month Pregnant at time of death Day Year the 9 Unknown Unknown signed by to be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics

1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

MSKay Apalnem D 29d. Date signed (Month, Day, Year) 8/3/11 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S. Rajapakse M.D. 2835 Smin N. S. Zo3 Baltimore MD 21209

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar 31. Date filed (Month, Day, Year) 0 2011 AUG 1

5 Pending

Investigation

determined

H.S. Rajapakse M.O

6 Could not be

1 Natural

2 Accident

3 ☐ Suicide 4 ☐ Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 30 per dyr g918 8-10-11 yt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ KATHARINA STANL 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MASHINGTON MEDICA ARUNDE GLEN BURNI ANNE BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (/n 8. Date of Birth **Funeral** Months Hours (Month, Day, Country) Germany 181-32-3202 89 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 Yes 2 😾 No Maryland Anne Arundel Severn 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21144 103 Denson Drive within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Deceden 2.1 Armed Forces? 1 ☐ Yes 2 🎇 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Waitress and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Karl Schroeder Elisabeth Allman 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 10405 West Dora Circle, Wichita, Kansas 67209 Hannelore Garrett 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ArdentCremation, Inc. 8-10-11 Hanover, Maryland 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee 6009 Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Examir sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBSTRUCTIVE PULMONARY Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available CORONARY 24a. Was an cate has I page 2 s prior to completion death? autopsy performed this certificate 2 No Yes 2 V 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 2 No ဂ္ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🔲 Yes Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to ompleted filled in by the funeral 1 Natural 5  $\square$  Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) TARAL REDDY 8 2011 ame and address of person who completed cause of death (Item 23a) (Type, Print) 1910 Towne Centre Blvd. Annapolis, Md. 21401 Tarau Reddy 31. Date filed (Month, Day, Year) State AUG 1 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 25486 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 2011 ames 9: 23 a.M. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST. Asnes He-pital Saltimore Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours Min -36-835 1 M 2 D F Märch Director Yrs or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 21tm 1 Ges 2 No 10f. Zip Code 10g. Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, If Yes, specify Cuban Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ac 1 Yes 2 No If Yes, Give Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility towell 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Due to (or as or nsequence of): JNK now N anter Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Completed by Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Year 2 No by the a 9 Unknown g 🗍 Unknown P.O. | by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy performed 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Certificate: To 2 No Other: 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 2 29d. Date signed (Month, Day, Year) AULUST, 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lawre Bry, MD 900 Caron Aur, Bultimore. MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Sm/

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death 25487 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Year Month Dennis Melvin Scarborough 2:03 AM 201 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner Medical** 500 Upper Chasapeake Hactord <del>ि</del> Center If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min (Month, Day, Yout 14, Director 1922 Maryland Oct 216-12-6893 88 Usual Residence of Decedent 28a-f show 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 No Bel Air Harford MD 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral "natural", or items 23a USA 21014 128 W. Ring Factory Rd #1326 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 X Yes 2 No 1945 Black, White, etc. 1 Never Married 2 X Married ð Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 - Widowed 4 - Divorced 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) restaurant equipment 12 salesperson Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bessie E. Kelly Melvin Scarborough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 W. Ring Factory Rd #1326; Bel Air, MD 21014 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Ruth Scarborough - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) e o I ervice Lice 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phy i i Du-lo (or as a consequence of) 6/2 disease or condition resulting in death) Medical Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for Month Dav Year 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page 2 1 Yes 2 No Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Certificate: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 [ 29b. Signature and title of o 29d. Date signed (Month, Day, Year, 00057223 who completed cause of death (Item 23a) (Type, Print) Name and address of pers 500 upper Chesapenke

State

Registrar

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31. Date filed (Month, Day,

Year

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5<sup>Day</sup> Physician/ AUGUST 2011 DONATO 9:40 РМ VITO SACCO Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HARFORD FOREST HILL HEALTH & REHABILITATION FOREST HILL If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 4, 1920 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 D F Months Pennsylvania Director 207-05-0294 91 Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Maryland | Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō an "natural", or items 23a o Medical Examiner must be Funeral USA 21014 938 Felicia Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. δ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Retail Sales Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Marie Santoro Joseph Henry Sacco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau 938 Felicia Court, Bel Air, MD 21014 Joan E. Sacco / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State Crownsville VA Cem. 8-9-2011 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. athleen Danti Vacci 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Congestias Physician/ heart Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): physician and the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 1 Yes 2 No ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed or Attending Physician: The 2 No ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director, Be Hospital: Other: 4 X Nursing Home 3 Presidence 6 Other (Specify) 1 Yes 2 No ٥ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After work? 1 ☐ Yes 2 ☐ No. 1 Natural injury 5 Pending ☐ Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number & TD 903035 8 501 0 3227 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 141 21014 BEL AIR, MD 615 W. MACPHAIL ROAD

Registrar DHMH 17 Rev 7/2009

State

DR. DAVID DUNN 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O. I

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend#5perfng918 8-16-11 d.o. State of Maryland / Department of Health and Mental Hygiene 25489 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O 4 1825 VIN 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign If Unde **Funeral** 217-22-0148 Days Months Hours Min. 1072271926 1 XM 2 - F Maryland Director 84 Vrs Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No N/A MD Baltimore 10e, Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a Carrollton Ave. 21223 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò by 1 X Never Married 2 Married 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday\_(0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12th Grade unemployed N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bernard Taylor Hilda Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Ramona Beasley(niece) 826 W. Saratoga St., Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Removal from State 4 Donation 5 Other (Specify) Garrison Forest 08/15/11 Owings Mills, MD Signature of Funeral Service Licensee Joseph Address of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Ballimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Metabolic disease or condition Medical resulting in death) **Examiner** Introvascular Conquilation sseminated Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events HEMOTThage Gas trointestinal resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 phy. inding puse as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Pregnant at time of death Yes 2 No 1 ∐ Yes 2 L 9 ☐ Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending s after death.

I Director: Aft
d In by the fur Accident
Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) MD 2224 30. Name and ress of person who completed cause of death (Item 23a) (Type, Print) GREENT

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

AUG

DHMH 17 Rev 7/2009

State

Registrar

3455

32. Registrar's Signature

WILKERS Ave. Ste LIO, BALTIMORE MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

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WiD

	•	For State Registrar		yland / De <i>C</i>	ertificate d				g. NZ U I	25491
- ·		1. Decedent's Name (First, Middle, L	_ast)					Date of Death Month	Day Year	3. Time of Death
Physician /Medical		Martin Ernest	Teasley					ugust	06 201	1 12:08P <sup>M</sup>
Examiner		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town	n, or Location	of Death		4c. County of Dea	ith
		3009 Pennsylvan				horpe	0411		Baltimo	
Funeral			. Sex 7. Age (III	In yrs. last birthda	Months   Da		Min. 8. I	Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreigr ountry)
Director		267-29-4445	1 E 3 W 2 C T	53			0	7/19/1	958   Geo	orgia
*		Usual Residence of Decedent  10a. State 10b. County	10	Dc. City, Town or	Location					10d. Inside City Limits
notified at	5									1 XYes 2 No
1	ect	MD Baltim	ore	Haleth	10f. Zip Cod	Io		10	g. Citizen of What C	ountry?
ast ban	5									,
Examinar must be by Funeral D	era	3009 Pennsylvan	12. Was Decedent Eve	rin IIS 1	2122		igin? (Specify	Yes or No-	U.S.A.	erican Indian.
	Funeral Director	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	Armed Forces?	7 11 0.0.	3. Was Decedent If Yes, specify (	Cuban, Mexicar	n, Puerto Rica	an, etc.)	Black, Whi	
		3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🛣	No Specify:			Specify:	White
1 8	Completed by	15. Decedent's		16a. De	cedent's Usual Oc	cupation		1	6b. Kind of Business	
A Part		(Specify only highest	grade completed)	(G life	ive kind of work do a. DO NOT use re	ne during mos tired)	t of working			
far fr	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Painter				Constru	ction
ent,	D P	17. Father's Name (First, Middle, La	ist)			18. Mothe	er's Name (Fi	rst, Middle, M	laiden Surname)	
atic ev	9	William Austi	in Teasley			Jud	lith	Dan	kwood	
Imat	-	19a. Informant's Name/Relationship		19b. M	ailing Address (Str			oute Number,	City or Town, State,	Zip Code)
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othe		20a. Method of Disposition		20b. Place of Dis	sposition (Name or rematory or other	f	Date		Oc. Location - City o	
y or		1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spe		•	Sifts Regis	i_	8/09/2	отт н	lanover, M	arvland
프		21. Signature of Funeral Service		Anacally C					fts Regis	
any Ir		1 601							Hanover,	
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for use as	<u> </u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 ☐ Ectopic pregr	nancy			23d. Date of d	
d for	Sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at tir		5 Other (specif				Month	Day Year
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	by Physician/Me	Part II. Other significant condition	s contributing to death but r	not resulting in th	e underlying cause	e given in Part	i.			to the cause of death?
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should	pleted							24a. Was ar		o completion of cause of
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page 2 should	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 □ Inpatient	2 ☐ ER/Outpa	itient 3 □ DOA	Other:		autops perform 1 □ Yes 2 Check only one	y prior to death?  2	o completion of cause of ? es 2 □ No
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led in by the funeral director, page 2 should Cartification: To Re Completed	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28a. Date of Injury (Month, Day, Y tition at be 28e. Place of Injury building, etc. (  Physician: To the best of r xaminer: On the basis of ex	/- At home, farm (Specify)  my knowledge, d xamination and/d	e of ry M 28c. M street, factory, off eath occurred at to rinvestigation, in 29c. Li	Other: 4 N Injury at Work? 1 Yes 2 Cice  the time, date a my opinion, decense number	Iursing Home 28d 28d 28f. and place, and place, and place and plac	autops: perform 1	prior to death of the prior to death of the	o completion of cause of a set

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 5:25 A M August <u>Mable Agnes Wedberg</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Wilson Healthcare Gaithersburg 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year **Funeral** 1 □ M 2 🛛 F Months sept 29 Yrs 1922 Texas **Director** 466-36-0474 88 Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No Rockville Maryland Montgomery 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a United States 622 Goldsborough Drive 20850 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married "natural", or ð 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education 5+ Teacher Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Eula NeFerris Powell John Oliver McBee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 10504 Westlake Dr. #303 West Bethesda, MD 20817 Susan Kirk Schwarz / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Journey Crematory 8/4/2011 Woodbine, Maryland permit. 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M MD 21029 MO1251 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Criset and Death Immediate Cause (Final caral loke infor Phy i i disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Examine Due to for as a ponsecuence of cause. Enter Underlying the burial-transi Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death be detached P.O. ģ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy bide performed 1 Yes 2 No **Division of Vital** or Attending Physician: 25. Was case referred to medical director. Be 26. Place of De ... (Check only one) examiner? 12 Other: 1 Yes 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 Natural Natural
Accident
Suic 5  $\square$  Pending work 2 🗌 No 1 Tes Investigation within 24 hours after deat To the Funeral Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined

Registrar

completed

C

Medical

29a. Certifier

3 🗆

IN-DUBERT Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

29b. Signature and title of certifier

To the Hospital

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

BOIRUSELL AU GAITHERS BURG

ernon William		1- For State Registrar Certificate of Death Reg. No. 2011											
Physic ledical Exam		VERNON	WILI	LIAMS	JR.			2. Date of Dea Month August 1,		r	3. Time of Death 1623 hrs		
<i>Y</i>		4a. Facility Name (if not institution  Johns Hopkins Hospi		mber)		4b. City, Town, or I Baltimore	Location of Deat		4c. County o	f Death			
Funeral Director		5. Social Security Number unk	6. Sex	7. Age (In yrs.	last birthday) 43 Yrs	If Under 1 Year Months Days			irth(MM/DD/YYYY)	Foreign			
any	1	Usual Residence of Decedent  10a. State 10b. County			y, Town or Locat				-1907		10d. Inside City Limits		
<b>E</b> .	, i	1.00		100. 0,	, Town or Education	BALTI	IMORE				1 X Yes 2 No		
th the Maryland 23n or 28n-f sho notified at once	Director	10e. Street and Number		1		10f. Zip Code		1	10g. Citizen of Wha	at Coun	try?		
with the as 23a o		2743 E. CHASE		cedent Ever in U	J.S. 13. W	2120 as Decedent of Hisp		Specify Yes or No		U.S.A.  14. Race - American Indian, Black,			
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiest and state at a marked other than "natural", ar items 23a or 28a-fabo are: If item 27 is marked other than "natural", ar items 23a or 28a-fabo ar other tranmatic event, the Medical Examiner must be notified at once	y Funeral	1 Never Married 2 M	farried Armed Fo	orces?		Yes, specify Cuban,	, Mexican, Puerto						
hours at matural	ed by	45 0	l or Dates: ecify only highest grad	de completed)		nt's Usual Occupation	on (Give kind of		16b. Kind of Bus				
5-0036 led within 72 hours af tygiene. other than "natural the Medical Examin.	Completed	Elementary/Secondary (0-12)	College (1-	-4 or 5+)		RICIAN	DO 1101 200	ili 6u)	ELECTR	ICAI			
AD 21215-0036 2 should be filed within 7 1 and Mental Hygiene. 27 is marked other than matic event, the Medica						1			st, Middle, Maiden Surname)				
212 ould be J Menta s marke	To Be	VERNON WILLIAM  19a. Informant's Name/Relations			19b. Mailin	g Address (Street	DIANE WI and Number or		mber, City or Town	ı. State,	Zip Code)		
G, MD 1 and 2 sho Health and item 27 is		DIANE WILLIAMS 20a. Method of Disposition	MOTHER	Lanh	6050	MORAVIA E	PK DR.	BALTIMO	RE, MD	2120	06		
Baltimore, permit. Pages I an Pepartment of Heal mportant: If itel night or other tr		1 Burial 2 X Cremation		om State	crematory or oth			Date	20c. Location - (				
Baltimore permit. Pages 1 Department of H Important: If i		4 Donation 5 Other Sc 21. Signature of Funeral Service		BA		REMATORY Name and Address of LLERS MET	of Facility	-10-2011	BALTIMO	RE,	MD		
of 웹스트로 Physician		23a/Part I. Enter the disease, or	complications that ca	weed the death	112	06 W. NOE	RTH AVE.	. BALTIM	IORE, MD	2121			
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	otic (M	orphine	) Intoxic		or respiratory and	est, snock, or near		Approximate Interval Between Onset and Death		
		Sequentially list conditions,	b										
	Examiner	if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated	С		,								
ecuted and transit		events resulting in death) Last	Due to (or as a o	consequence o	₹):								
be ex iician urial	edical	X UNPENDED	AMENDED	l as no	ted, 23	3a,27,28a	-f per 1	ne g918	8-29-11	vt			
0 0 0 0		IF FEMALE: 23b. Was decedent pregnant in th past 12 months?	23c. If yes, ou	outcome of pregi		tal death 3	Ectopic pregna	ancy	23d. Date of de Month	lelivery Da	ay Year		
i, P.O. Box 6876( res that the death certificate signed by the attending phys be detached for use as the b	Physician/M	1 Yes 2 No 9 Unk	known 9 Unknov		eath 5 Oth	her (Specify)							
S, P.O. Lires that the signed by d be detach	þ	Part II. Other significant conditi	ons contributing to	death but not re	esulting in the ur	inderlying cause giv	en in Part I.		obacco use contribu		ne cause of death?		
Division of Vital Records, To the Hospital or Attending Physician: The law requirt within 24 hours after death.  To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be	Completed							24a. Was a autop: perfor 1 ✓ Yes 2	rmed? dea	or to co	ppsy findings available mpletion of cause of		
1 of Vital Recoing Physician: The law After this certificate has funeral director, page 2 s.	Be	25. Was case referred to medical examiner?	[Hospital:				of Death (Check	only one)	2 110	<b>✓</b> Yes	2 No		
Of VIII	P	1 Yes 2 No 27. Manner of Death	28a. Date of	of Injury	ER/Outpatient 28b. Time of In		other Nursin		Residence 6 now injury occurred	Other			
ion (ttending leath.	ation	1 Natural 5 Pendi 2 Accident Invest	(Month, D	Day, Year)	fd 4:00	1 Va		unknown					
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could determ	28e Place	of Injury - At ho		et, factory, office buil		28f. Location (S or Town, St Baltimo	tate) 27/3 E	or Rura	Route Number, City		
fo the Hos vithin 24 h Fo the Fun completely	Medical (	29a. Certifier (Check only one) 2 Medical Exam	nysician: To the best of miner:On the basis of and manner sta	f examination ar	ge, death occurr nd/or investigati	ed at the time, date ion, in my opinion, c	e and place, and	due to the cause	e(s) and manner a	s stated	cause(s)		
	Ž	29b. Signature and title of certifier		8		29c. License r O.C.M.			29d. Date signed August 2, 20		7, Day, Year)		
		30. Name and address of person v Melissa Brassell, MD	who completed cause Assistant Medi	•		Baltimore Str	eet, Baltimo	re, MD 2122					
Sta Regist		31. Date filed (Month Day Year) 2011 2. Registrar's Signature AUG 1 () 2011 2. Registrar's Signature											

DHMH 17 Rev 1/2001

ORI

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ WILLIAMS Month IOHN :55 P M UGUST 20/1 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** PAMALUST NORTHWES BALTIMORE OWN If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign If Under Funeral 1 Year Days 1 🛣 M 2 🗆 F 79 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director MD Baltimore Nottingham 1 Yes 2 XNo 6 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 15 Arlen Court 21236 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No Navy
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. and Mental Hygiene. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2X No Specify: Specify: White 3XXWidowed 4 ☐ Divorced Year or Dates. 1949-69 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pharmacist Healthcare 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental item 27 is marked o John Henry Williams Flossie Emery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3213 Smith Ave., Pikesville, MD 21208 Jeffrey Craig Williams/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) remetery, crematory or other place)
Final Journey Crem. 8/10//2011 Woodbine, MD 21. Signature of Funeral Service Livensee Dorfota Marshall 22. Name and Address of Facility Maryland Cremation Services Marshan Box 1413. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between THEROSCLEROTIC CARDIOVASCULAR Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IE FEMALE: for use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. signed by the Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: 2 No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manyler of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending within 24 hours after death.

To the Funeral Director: A 1 Yes 2 No Accident Investigation completed filled in by the 3 ☐ Sulcide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa 6 certifie 29c. License number 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROTHKIN 5401 OVD COURT 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 1 per doc g918 8-10-11 vt
State of Maryland / Department of Health and Mental Hygiene for State Registrar 25495 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month August Physician/ 6:58 P M John Wilbert John Wilburn Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Seasons Hospice If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 ▼ M 2 □ F Months Days Hours (Month, Day, Year) 220-30-3694 **Director** 15 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County with the Maryland notified at Director Catonsville 28a-f Baltimore 1 Yes 2 No MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ö ral", or items 23a or Examiner must be Funeral U.S.A. 21228 6214 Ethel Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc 1 Never Married 2 Married þ altimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 ☐ Divorced "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) 8th grade College (1-4 or 5+) Steam Ship Trade Longshoreman Be 47. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maggie Jackson ဂ Theoto Wilburn permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6214 Ethel Ave, Catonsville, Md 21228 19a. Informant's Name/Relationship (Type, Print) Vernessa Barnes-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 8/10/2011 Laurel, Md National 21. Signature of Juneral Service Lic-22 Name and Address of Facility March F/H West RA 21215 4300 Wabash ave, Baltimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atheroscierotic Cardiovascular Disease Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Daw to (or as a nor sequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 ${\mathcal E}$ attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day signed by the at d be detached for g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed has certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Vother (Specify) 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check MSRy apahseMID 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00057465 815/11

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day Year, AUG 1

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AV 5-203 Baltimore MD 21209

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	п	Physicia Medi		1. Desedent's Name (F	irst, Middle Last,	1 /	Ker	Sr.			2. Date of D Month Aug	eath Day	Year		e of Death
	0	Examir		4a Eacility Name (if no:	t institution, give s	treet and number)	La	4b.	City, Town, or	Location of Dea		4c. 0	County of De		
	*	Funeral Director		5. Social Security Number			e (In yrs. last	birthday) If U	Inder 1 Year ths Days	If Under 24 Hrs Hours Min		1193	<b>9</b> 9. E	Birthplace (Sta	ate or Foreign
			1.	Usual Residence of De	cedent 0b. County		10c City	Town or Location			1111-1	1110		10d Incid	e City Limits
		Marylar 28a-f sl	Director	MD				Himor							Yes 2 No
		1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral D	406 Al	lendale	e Street	et	10	f. Zip Code	129		10g. Citiz	en of What (	Country?	
	9	er death or item miner m	by Fur	11. Marital Status 1  Never Married		12. Was Decedent B Armed Forces? 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \)	_	If Yes,	specify Cubar	spanic Origin? (S n, Mexican, Puer	pecify Yes or No to Rican, etc.)	- 1	4. Race - An Black, Wh	nerican Indiar nite, etc.	1,
	21215-0036	within 72 hours after giene. er than "natural", or , the Medical Exami		3 Widowed 4 1	Divorced  5. Decedent's Edi	If Yes, Give Year or Dates.		1 ☐ Y	es 2 No				pecify:	Black	ر
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		e filed w ntal Hygi ed other event, t	To Be	17. Father's Name (Firs	t, Middle, (ast)	1.		SICTIO	7	18. Mother's Na	me (First, Middle	, Maiden Su	ırname)	<i>ltimo</i>	
_	Maryland	2 should be filed within 72 th and Mental Hygiene. 77 is marked other than " traumatic event, the Med		1 formant's Name	/Relationship (Typ			19b. Mailing Add	iress (Street a	nd Number or Ri	SSi e ur#Route Numb	er, City or To	own, State, 2	Zip Code)	
3DAM	_	f Health f Health item 27 other tra		20a. Method of Disposi	D. Wal	Ker (a	20b. Plac	e of Disposition	Vembe (Name of	er St.,	<u>Garne</u>	<u>r, 1</u>	VC .	275	27
.32	Baltimore,	Page ment o ant: If ary or		4 Donation 5	Other (Specify)	A	MI	etery gematory	or other place	<b>8</b> -		Bay	timo	re D	D
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%			iner	Sequentially list condit	ions, t	Due to (or as a	consequen	ee orj:	s her	P Tak	rease.			104	75
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Nalker	Box 68	Firstcian: The law requires that the death centificate be this certificate has been signed by the attending physic ral director, page 2 should be detached for use as the but		IF FEMALE: 23b. Was decedent pre- in the past 12 mon	gricant	3c. If yes, outcome	2 🗌 Fetal d	eath 3 🗌 Ecto	pic pregnancy	/		23	3d. Date of c	lelivery Day	Year
$\frac{2}{5}$	O. Bo	t the des by the a tached f	Physic	1 Yes 2 N 9 Unknown		4 ☐ Pregnant at 9 ☐ Unknown							WOITH	Day	Teal
J	ls, P.	ures ma n signed uld be de	ed by	Part II. Other significar	nt conditions con	tributing to death b	ut not resulti	ng in the underly	ing cause give	en in Part I.				to the cause	,
-	Record	has beer	Completed by								24a. Was	psy	prior to	autopsy findin completion	gs available of cause of
Char	tal Re	artificate ctor, pag	Be Co	25. Was case referred to examiner?					26. Pla	ce of Death (Che		ormed? 2 No	death?	es 2 No	
	of Vit	rriysid er this ce eral dire	e: To Be	1 Yes 2 No.		28a. Date of injur	y 28	Outpatient 3 D	28c. Injury	4 Mursing I at	dome 5 Resi			ecify)	
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	Divis	urs after ral Direc	al Cer	4  Homicide	determined	28e. Place of Inju building, etc	. (Specify)				28f. Location ( City or To	wn, State)			umber,
	Division O	To the hospital or Attentioning Priyacian; The law requires that the death certificate be within 24 burst after death.  To the Euneral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the burneral director.	Medical	(Check 2 🗀	Medical Examine	cian: To the best of or: On the basis of ex Practioner: To the	amination ar	d/or investigation	in my opinion	death occurred	at the time date	and place a	nd due to the	hac (s)asuch a	manner stated.
_	, in the second	Vith con		29b. Signature and title	of certifier		L	Hims	29c. License	number 0			signed (Mor	ith, Day, Year)	
15	V			30. Name and address of	of person who cor						imare				
1 1	S III	Stat	C .	31. Date filed (Mon h, Da	ay, rear	3 1 legis ra	r's Signatu	but	J	34"			- 144	0	
		Registra	ir	AU	G 1 0 201	Laure	. تر ر	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month GrusT ATH BRINE Physician/ 5.00 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death OWA 6011 Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day 1 □ M 2 🗙 F Hours Min Director Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 and 2 should be filled within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural". or items אים מאים יר אפים יר אפים יר 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No 10e. Street and Numbe 10g. Citizen of What Country? Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Informant's Name/Relationship (Type, Print) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10220 GUILFORD ROI 12550 B, MMD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Dav Pregnant at time of death cate has been signed by the a page 2 should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an prior to completion of death?

1 Yes 2 No within 24 hours after death. To the Funeral Director: After this certificate has performed director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 🗌 Yes 2 4 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5  $\square$  Pending Natural Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and title of certifier 29b. Signatur 29c. License number 29d, Date signed (Month, Day, Year) 8

Registrar
DHMH 17 Rev 7/2009

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 1 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25498 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month bert Whitlock 23:19 PM o >August 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sa Conter Baltimore HOSpital Franklin If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 09/26/1949 1 🕱 M 2 🗆 F Months Days Hours Min Director 61 213-52-4689 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Baltimore Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 9 Glenwood Road, U.S.A. Apt. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ò 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygien Important: If item 27 is marked any injury or cast. 10 Iron Worker Steel Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Leo Whitlock, Betty Lou Eggberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jhitlock, Bobbi Lee Whitlock / Daughter 6607 Glenoak Avenue, Baltimore, MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 08/09/2011 Hanover, Maryland Funeral Service Lice 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death sician רבי resouratory disease or condition Medical resulting in death) Due to r as a consequence Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and burial-tran Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical that the death certificate be P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year ☐ Pregnant at time of death☐ Unknown Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Division of Vital Records, coronary actery disease 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hypertension autopsy death? 2 X No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be completed filled in by the funeral director 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 😿 No ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined City or Town, State) Medical

State Registrar 29a. Certifier (Check

29b. Signature and title of cert

Date filed (Month, Day, Yea)

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cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29d. Date signed (Month. Dav. Year)

2011

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25499 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 24<sup>Day</sup> Rhonda Katherine Avant July 201T 08 40AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 1948 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 - M 2 X F Months Days Hours 578-66-5656 62 September 28, Washington, D.C. Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director 1 X Yes 2 No Maryland | Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16001 English Oaks Avenue; Apt. F 20716 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian the Medical Examiner Armed Forces? Black White etc. 1 X Never Married 2 Married δ Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Federal Emergency Elementary/Seconday (0-12) College (1-4 or 5+) Management Agency 12th grade Office Automation Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of pe 0tis Avant Mary Anderson permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16001 English Oaks Avenue; Apt. F; Bowie, Maryland 20716 Lamar Anthony Avant (Son) Date 29, 2011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Brentwood, Maryland Fort/Lincoln Cemetery 4 Donation 5 Other (Specify) ignatur of Funeral Service License 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory to Due to (ras a consequite of): Pnysician/ tuil disease or condition ays Medical resulting in death) Examiner Metastatic olon Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ stroke 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available 24a. Was an cate has by page 2 s prior to completion of cause of death? autopsy performed certificate 1 Yes 2 No Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Mann of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 No Accider
Suicide Accident Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours af

To the Funeral Di

completed filled in Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 060390 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

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Registrar

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2 8 2011

31. Date filed (Month, Day

32. Registrar's Signature

Arundel Medical Center,

			State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar Amend Item 25 per me, g921, 11/18/2011 dhb  Certificate of Death  Reg. N 20     2550	)
Н	Dhysicia	·n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death	
	Physicia Medic		Carolyn Abrahan Month 7 24 11 11 11 A	M
	Examin	er	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4d. County of Death	
1	Funeral	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign	n
	Director		578-60-7252   1 M 2 N F   67   Yrs.   Months   Days   Hours   Min.   (Month, Day, Year)   Gountry)   Sign   Country   Orth Carolina	L
	nd <b>how</b> at	٦	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limit	S
	farylar Ba-f s tified	ecto	Md Prince George's Hyattsville 1 ☑ Yes 2 □ N	
	the M	٥	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	h with	Funeral Director	3839 Hamilton Street #201 20781 USA	
	r deat or iten iner r		11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Ma	
980	s afte ral", c Exar	ed by	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ No Specify: Specify: Black	
2-0	2 hour "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working  16b. Kind of Business Industry	
121	thin 7 ane. than he Me	Som	Elementary/Seconday (0-12) College (1-4 or 5+) 2 College (1-4 or 5+) Administrative Assistant Federal Government	
d 2	lled wi I Hygi other rent, t	æ	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
/lan	d be fi Menta arked atic ev	오	Clinton Patterson Mamie Coleman	
Jan	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
e,	and 2 Health tem 2 ther t		Darin Tapscott / Son 3839 Hamilton St. #201 Hyattsville, Md 20781  20a. Method of Disposition (Name of Disposition	
Baltimore, Maryland 21215-0036	permit. Page 1 and Department of Hea Important: If item any injury or other once.		20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State   2	
a Ei	permit. Page Department Important: I any injury o		21. Signature of Fun + Strice Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home	
<u> </u>			Orda Marcis 3401 Bladensburg Rd. Brentwood, Md 20722	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between	
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-	_ +	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying	
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x 687	h cert tendin r use	ian/I	23b. Was decedent pregnant in the pact 12 months?  23c. If yes, outcome of pregnancy 1  Live Birth 2 Fetal death 3  Ectopic pregnancy 23d. Date of delivery	
Вох	e death the atte	Physician/Me	1 ☐ Pes 2 ☑ No 9 ☐ Unknown  4 ☐ Pregnant at time of death 5 ☐ Other (specify)	
O.	that th	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?	
o'S	quires an signant and be	ed b	1 🗆 Yes 2 🗀 No 3 🗀 Probably 4 🔀 Unknow	√n
SO	aw rec	Completed	24a. Was an autopsy findings available autopsy prior to completion of cause of	
Ř	: The l		performed?   death?   1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No	
Ita	sician certifi irector	o Be	25. Was case referred to medical examiner?  1 X yes  1 Y positions 3 DOA Other: A Musical Horse 5 Desidence 5 Desi	
6	g Phy er this neral d	te: To	27. Manner of Death  28a. Date of injury  28b. Time of  28c. Injury at  28d. Describe how injury occurred	
0	tendin earth. or: Afi the fui	Certificate:	1 Matural 5 □ Pending (Month, Day, Year) injury work? 2 □ Accident Investigation M 1 □ Yes 2 □ No	
Division of Vital Records,	or At after of Direct In by	Cert	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.	
	the Hin 24 hin 24 the Fu	Mec	(Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.	ted.
	© \$ € §		29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)	
,	اسما		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
R	15		22 S. Greene Street Beltimore MD 21201, Ellan Lewis mD	
	State Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature—  32. Registrar's Signature—  33. Date filed (Month, Day, Year)  34. Date filed (Month, Day, Year)	
			ANT A A Manager & Ma	